# MICHIGAN CANCER SURVEILLANCE PROGRAM
# CANCER PROGRAM MANUAL

Effective for January 1, 2011 diagnoses to date

Michigan Department of Community Health
Health Administration

Vital Records and Health Statistics Unit

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# MICHIGAN CANCER SURVEILLANCE PROGRAM
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Effective for January 1, 2011 diagnoses to date

Michigan Department of Community Health
Michigan Cancer Surveillance Program

DCH-0916 (6/11)
By Authority of Act 82, P.A. 1984

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**MICHIGAN CANCER SURVEILLANCE PROGRAM**
**CANCER PROGRAM MANUAL**

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## INTRODUCTION

The Michigan Department of Community Health is mandated by Act 82 of 1984, effective July 1, 1984, to establish a cancer registry for the state of Michigan. This statute states "the department shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state, and to record information concerning these cases as the department considers necessary and appropriate in order to conduct epidemiologic surveys of cancer and cancer-related diseases in the state."

Reports of diagnosed cancers are required of a facility diagnosing and/or treating a cancer patient. All hospitals, clinical laboratories, physician offices, dentists and clinic directors who have knowledge of a case of cancer shall report the case to the Michigan Department of Community Health.

Reporting of diagnosed cancers statewide is effective for those cases diagnosed on or after January 1, 1985. This manual is intended to provide those responsible for reporting with specific instructions on the proper and complete reporting of cancer diagnoses.

In October 1, 2004, the MCSP started collecting benign borderline intracranial and CNS tumors.

If you should need further assistance, please contact the following staff:

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## HISTORY OF THE MICHIGAN CENTRAL CANCER REGISTRY

The history of cancer reporting in Michigan dates back to 1947 when an administrative rule was enacted to require the reporting of cancer cases. This rule was never effectively enforced until 1978, when a governor's task force was empanelled to examine the need for cancer reporting in Michigan. The recommendations from this panel prompted the department in 1980, to initiate a pilot program. By 1984, 52 hospitals were reporting cancer cases on a voluntary basis, which resulted in approximately 6,000 cases being reported each year. As the pilot project progressed, legislation to require state wide reporting was developed. On April 17, 1984, a bill to mandate state wide reporting was signed into law.

A panel was assembled to develop and design the rules for reporting incidence of cancer to the state wide central cancer registry. In 1984, the "Task Force on Administrative Rules to Implement Act 82" began meeting. The task force consisted of professional groups throughout the state who in some way dealt with cancer patients or cancer data systems. In addition, public health officials involved in health programs concerned with cancer control, and individuals involved with epidemiological cancer research, were also assigned to the task force.

The objective of the task force was to "provide advice to the department on a set of administrative rules as required by the authorizing legislation." This panel made recommendations on data items to be collected, methods of reporting, quality control issues, confidentiality, as well as rules for reporting facilities. These cancer reporting rules were developed and outlined in the original Cancer Reporting Manual 1984, which was approved by the original task force. On January 1, 1985, the rules for reporting cancer cases went into effect.

The Michigan Cancer Surveillance Program (MCSP) began tabulating cancer incidence reports on January 1, 1985. By the end of 2005, the state central cancer registry contained 1.5 million reports with 1 million individual cancer cases. These cases represent approximately 180 reporting facilities, which include hospitals, physician offices and laboratories.

The Detroit Metropolitan Cancer Surveillance System operates a Surveillance Epidemiology End Results (SEER) registry which reports for all hospitals and most laboratories within Oakland, Macomb, and Wayne counties. The SEER registry represents approximately 100 hospitals and laboratories in these three counties. Other regional registries include the West Michigan Cancer Center in Kalamazoo and the cancer registry at Marquette General Hospital in Marquette.

Facilities report cancer cases to the state central cancer registry either manually on paper or automated with computer data files. Hospital registries are becoming more sophisticated in their collection and transferal methods since the state cancer registry began in 1985. As of October 2007, approximately 90 percent of the cases from hospitals and regional registries are involved in an automated reporting system. Automated facilities send their data to the state registry either by floppy disk, compact diskette or via a FTP site.

State cancer data is compiled and analyzed every year. An annual report is produced using the submitted data and is available on our website at www.michigan.gov/mdch. To date, nineteen annual reports have been published for the years 1985 through 2006. As new annual reports are prepared, updated data for prior years is developed and released to ensure that the most complete information is made available. Processing time for a report from diagnosis to manual statistics is approximately two years.

## PURPOSE

A state wide population based cancer registry is the only means whereby state wide incidence data for cancers by type and by area of residence can be developed. Timely information on cancer cases is employed as a basis for cancer surveillance, as a tool for initial evaluation of cancer incidence within regions of particular interest, and as a source of baseline incidence data. The registry is of value in examining the frequency of cancer by demographic characteristics such as age, race and sex and is of significant value to researchers in epidemiological case control studies. This data is also helpful in the areas of planning health education and addressing public health concerns.

## CONFIDENTIALITY

Cancer incidence reports and data files on cancer cases which are received by the department are afforded confidential handling as required by Act 82 of 1984, being section 2631 of Act 368 of 1978 as amended, and by administrative rule. The release of data in identifiable form is specifically prohibited, except as outlined in Rule Four. Under the rules, release of this data or reports is permitted to the individual patient or to the patient's legal representative. Information may be provided to a researcher conducting approved research, following specific protocol based upon the nature of the research. Release is permitted to a cancer registry from another state with regard to residents of that state so long as the state agrees to restrict the use of the information to statistical tabulations. Further protection of the data is afforded by sections 2632 and 2633 of Act 368 of 1978 which designates that the reports or information thereon are inadmissible as evidence in a court and which establishes a shield from liability for furnishing the information. In addition, the privacy regulations enacted in conjunction with the Health Insurance Portability and Accountability Act (HIPAA) has a specific exemption to permit disclosing identifiable patient data to the official public health agency of a state

## REVISED REPORTING REQUIREMENTS

In 2009, changes to the information being reported for 2010 cancer cases was initiated. These new reporting standards are designed to ensure that the registry in Michigan conforms as closely to central incidence registries operated in other states. The new data set collected conforms to the items recommended for collection by the North American Association of Central Cancer Registries (NAACCR) and are nearly the same as the recommendations by the National Program for Cancer Registries (NPCR).

The decision to change the reporting requirements was precipitated by two important developments. The first was the release of standards for the operation of a central registry which were produced by NAACCR in 2010. Concurrent with the release of these new standards were recommendations on standard items for collection released by NPCR within the Centers for Disease Control. The information being collected in Michigan did not conform to these two new sets of standards. It was apparent that the long term usefulness of the state central cancer registry hinged upon careful review of the new standards and the development of specific recommendations for implementation in Michigan.

The initial structure for cancer reporting used in Michigan was developed in consultation with an "ad hoc task force" with members representing key organizations of cancer care and cancer research in Michigan. This group provided counsel on a number of important matters that needed to be addressed when the registry was first established. These issues included determining who was responsible for reporting, the

manner the information was to be reported, timeliness requirements, and finally the items to be reported. The advice of this group proved to be an important key to the success of the state wide cancer registry. This same approach was adopted with regard to re-evaluating the basic operational principles for the Michigan registry in light of the recommendations of NAACCR and NPCR.

The standards set forth by the Commission on Cancer (COC) were also taken under advisement. A strategy for required data sets takes place in a tiered priority which conforms to the requirements of the COC. Those facilities approved by the COC, are required to submit more detailed information, which includes further information on staging and treatment. Those facilities with COC approved cancer registries are perceived to have the ability of their staff to supply the central registry with this further information. A table has been developed to distinguish the reporting requirements for approved facilities, non-approved facilities and laboratories.

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Act No. 82
Public Acts of 1984
Approved by the Governor
April 17, 1984

Filed with the Secretary of State
April 19, 1984

**STATE OF MICHIGAN**
**82ND LEGISLATURE**
**REGULAR SESSION OF 1984**

Introduced by Reps. Spaniola, Hertel, Barns, Dutko, Porreca, Sitz, Maynard and DeMars

# ENROLLED HOUSE BILL No. 4090

AN ACT to amend Act No. 368 of the Public Acts of 1978, entitled AAn act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties for governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide the certain immunity from liability; to provide for penalties and remedies; and to repeal certain acts and parts of acts," as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, by adding section 2619.

*The People of the State of Michigan enact:*

Section 1. Act No. 368 of the Public Acts of 1978, as amended, bing sections 333.1101 to 333.25211 of the Michigan Compiled Laws, is amended by adding section 2619 to read as follows:

Sec. 2619. (1) The department shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state, and to record information concerning these cases as the department considers necessary and appropriate in order to conduct epidemiologic surveys of cancer and cancer-related diseases in the state.

(2) Each diagnosed case of cancer and other specified tumorous and precancerous diseases shall be reported to the department pursuant to subsection (4), or reported to a cancer reporting registry if the cancer reporting registry meets standards established pursuant to subsection (4) to ensure that accuracy and completeness of the reported information. A person or facility required to report a diagnosis pursuant to subsection (4) may elect to report the diagnosis to the state through an existing cancer registry only if the registry meets minimum reporting standards established by the department.

(3) The department shall maintain comprehensive records of all reports submitted pursuant to this section. These report shall be subject to the same requirements of confidentiality as provided in section 2631 for data or records concerning medical research projects.

(4) The director shall promulgate rules which provide for all of the following:

(a) A list of tumorous and precancerous disease other than cancer to be reported pursuant to subsection (2).

(b) The quality and manner in which the cases and other information described in subsection (1) are reported to the department.

(c) The terms and conditions under which records disclosing the name and medical condition of a specific individual and

kept pursuant to this section are released by the department.
(5) This section does not compel an individual to submit to medical or department examination or supervision.
(6) The department may contract for the collection and analysis of, and research related to, the epidemiologic data required under this section.
(7) Within 2 years after the effective date of this section, the department shall begin evaluating the reports collected pursuant to subsection (2). The department shall publish and make available to the public reports summarizing the information collected. The first summary report shall be published not later than 180 days after the end of the first 2 full calendar years after the effective date of this section. Subsequent annual summary reports shall be made on a full calendar year basis and published not later than 180 days after the end of each calendar year.
(8) Reporting pursuant to subsection (2) shall begin the next calendar year after the effective date of this section.
(9) This section shall take effect July 1, 1984.

This act is ordered to take immediate effect.

William A. Ryan
.....
Clerk of the House of Representatives.

William C. Kandler
.....
Secretary of the Senate.

Approved. . . . . .

. . . . . .
Governor.

DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF THE STATE REGISTRAR

CANCER REPORTING

Filed with the Secretary of State on April 16, 1985. These rules take effect 15 days after filing with the Secretary of State.

(By authority conferred on the department of public health by section 2619 of Act No. 368 of the Public Acts of 1978, as amended, being 333.2619 of the Michigan Compiled Laws)

**R 325.9050 Registry**

Rule 9050. (1) The department shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state. The registry shall include information concerning these cases as the department considers necessary and appropriate to conduct epidemiologic surveys of cancer and cancer-related diseases in the state.

(2) Each diagnosed case of cancer and other specified tumorous and precancerous diseases shall be reported to the department pursuant to subrule (4) of this rule, or reported to a cancer reporting registry if the cancer reporting registry meets standards established pursuant to subrule (4) of this rule to ensure the accuracy and completeness of the reported information. A person or facility required to report a diagnosis pursuant to subrule (4) of this rule may elect to report the diagnosis to the state through an existing cancer registry only if the registry meets minimum reporting standards established by the department.

(3) The department shall maintain comprehensive records of all reports submitted pursuant to this rule. These reports shall be subject to the same requirements of confidentiality as provided in section 2631 of 1978 PA 368, MCL 333.2619 for data or records concerning medical research projects.

(4) The director shall provide for all of the following:

(a) A list of tumorous and precancerous disease other than cancer to be reported pursuant to subrule (2) of this rule.

(b) The quality and manner in which the cases and other information described in subrule (1) of this rule are reported to the department.

(c) The terms and conditions under which records disclosing the name and medical condition of a specific individual and kept pursuant to this rule are released by the department.

(5) This rule does not require an individual to submit to medical or department examination or supervision.

(6) The department may contract for the collection and analysis of, and research related to, the epidemiologic data required by this rule.

(7) Within 2 years after the effective date of these rules, the department shall begin evaluating the reports collected pursuant to subrule (2) of this rule. The department shall publish and make available to the public reports summarizing the information collected. The first summary report shall be published not later than 180 days after the end of the first 2 full calendar years after the effective date of this rule. Subsequent annual summary reports shall be made on a full calendar year basis and published not later than 180 days after the end of each calendar year.

(8) Reporting pursuant to subrule (2) of this rule shall begin the next calendar year after the effective date of this rule.

History: 2004 MR 14, Eff. July 23, 2004.

**R 325.9051 Definitions**

Rule 9051. (1) As used in these rules:

(a) "Primary brain-related tumor" means a primary tumor, whether malignant or benign, of the brain, meninges, spinal cord, cauda equina, a cranial nerve or nerves, or any part of the central nervous system or of the pituitary gland, pineal gland, or craniopharyngeal gland.

(b)"Cancer" means all diagnosis with a behavior code of 2 (carcinoma in situ) or 3 (malignant primary site) as listed in the publication entitled "International Classification of Diseases for Oncology," 1976, excluding basal, epithelial, papillary, and squamous cell carcinomas of the skin, but including carcinomas of skin of the vagina, prepuce, clitoris, vulva, labia, penis, and scrotum.

(c) "Department" means the department of community health.

(2) The terms "clinical laboratory" and "hospital," as defined in sections 20104 and 20106, respectively, of 1978 PA 368 and MCL 333.20106 have the same meanings when used in these rules.

History: 1985 MR 4, Eff. May 2, 1985; 2004 MR 14, Eff. July 23, 2004.

**R 325.9052 Reportable diagnoses**

Rule 9052. (1) Cancer diagnoses, diagnoses of benign brain-related tumors and any tumorous and precancerous diseases otherwise required to be reported by state or federal law shall be reported to the department in a manner consistent with these rules and procedures issued by the department.

(2) Diagnoses shall be reported by all hospitals and clinical laboratories.

(3) A hospital or clinical laboratory may elect to report cases through a hospital or regional cancer registry that meets the rules set by the department.

(4) Reports shall be submitted within 180 days of a diagnosis on a form prescribed or approved by the department, except for reports forwarded on electronic media.

(5) Reports submitted on electronic media shall meet data quality, format, and timeliness standards prescribed by the department.

History: 1985 MR 4, Eff. May 2, 1985; 2004 MR 14, Eff. July 23, 2004.

**R 325.9053 Quality assurance.**

Rule 3. (1) For the purpose of assuring the quality of submitted data, each reporting entity shall allow the department to inspect such parts of a patient's medical records as are necessary to verify the accuracy of submitted data.

(2) A reporting entity which meets the standards of quality and completeness set by the department shall be subject to inspection not more than once every 2 years for the purpose of assessing the quality and completeness of reporting from the entity.

(3) A reporting entity shall, upon request of the department, supply missing information, if known, or clarify information submitted to the department.

(4) Upon mutual agreement between a reporting entity and the department, the reporting entity may elect to submit copies of medical records instead of inspection. Each copy of a medical record or part thereof submitted to the department pursuant to this rule shall be used only for verification of corresponding reported data, shall not be recopied by the department, and shall be kept in a locked file cabinet when not being used. Such copies shall be destroyed promptly following verification of the corresponding reported data or, if the reported data appears to be inaccurate, following clarification or correction of the reported data.

(5) Both of the following provisions shall be complied with to preserve the confidentiality of each patient's medical records:

(a) Each reporting entity shall provide to the department, for inspection only, all of the following records and reports:

(i) Reports of tissue analyses which have been performed for the purpose of determining the presence or absence of malignant disease.

(ii) Reports of radiological examinations performed for the purpose of determining the presence or absence of malignant disease.
(iii) Reports of diagnoses of malignant disease and notations of the reasons for such diagnoses, including both the primary clinician's reports and consultation reports.
(iv) Those parts of medical records which contain the specific information required to be reported.
(b) A reporting entity shall not be required by this rule to allow inspection of any part of any patient's medical record other than those parts listed in subrule (3) of this rule. A reporting entity may allow the inspection of medical records from which parts, other than those specified, have been deleted, masked, crossed out, or otherwise rendered illegible.

History: 1985 MR 4, Eff. May 2, 1985.

**R 325.9054 Confidentiality of reports.**
Rule 4. (1) The department shall maintain the confidentiality of all reports of cancer submitted to the department and shall not release such reports, or any information which, because of name, identifying number, mark, or description, can be readily associated with a particular individual, except in accordance with subrules (2), (3), (4), and (5) of this rule. The department shall not release any information that would indicate whether or not the name of a particular person is listed in the cancer registry, except in accordance with subrules (2), (3), (4), and (5) of this rule.
(2) A report of cancer submitted to the department concerning a particular individual, and any other information maintained in the cancer reporting system which, because of name, identifying number, mark, or description, can be readily associated with a particular individual, shall be released as follows:
(a) To the particular individual upon compliance with both of the following provisions:
(i) Receipt of a written request which is signed by the particular individual and which is witnessed or notarized as required by subrule (3) of this rule.
(ii) Presentation by the particular individual of suitable identification as required by subrule (4) of this rule.
(b) If the particular individual is a minor, to a parent of the particular individual upon compliance with all of the following provisions:
(i) Receipt of a written request which is signed by the parent and which is witnessed or notarized as required by subrule (3) of this rule.
(ii) Receipt of a certified copy of the birth certificate of the particular individual.
(iii) Presentation by the parent of suitable identification as required by subrule (4) of this rule.
(c) If the particular individual has a court-appointed guardian or if the particular individual is deceased, to the court-appointed guardian or to the executor or administrator of the particular individual's estate upon compliance with all the following provisions:
(i) Receipt of a written request which is signed by the court-appointed guardian, executor, or administrator and which is witnessed or notarized as required by subrule (3) of this rule.
(ii) Receipt of a certified copy of the order or decree which appoints the guardian, executor, or administrator.
(iii) Presentation by the guardian, executor, or administrator of suitable identification as required by subrule (4) of this rule.
(d) To an attorney or other person designated by the particular individual upon compliance with both of the following provisions:
(i) Receipt of a written request which is signed by the particular individual, which is witnessed or notarized as required by subrule (3) of this rule, and which requests release of the information to the attorney or other person.
(ii) Presentation by the attorney or other person of suitable identification as required by subrule (4) of this rule.
(e) To an attorney or other person designated by the court-appointed guardian of the particular individual or designated by the executor or administrator of the estate of the particular individual upon compliance with all of the following provisions:

(i) Receipt of a written request which is signed by the court-appointed guardian, executor, or administrator, which is witnessed or notarized as required by subrule (3) of this rule, and which requests release of the information to the attorney or other person.
(ii) Receipt of a certified copy of the order or decree which appoints the guardian, executor, or administrator.
(iii) Presentation by the attorney or other person of suitable identification as required by subrule (4) of this rule.
(f) If the particular individual is a minor, to an attorney or other person designated by the parent of the particular individual upon compliance with all of the following provisions:
(i) Receipt of a written request which is signed by the parent, which is witnessed or notarized as required by subrule (3) of this rule, and which requests release of the information to the attorney or other person.
(ii) Receipt of a certified copy of the birth certificate of the particular individual.
(iii) Presentation by the attorney or other person of suitable identification as required by subrule (4) of this rule.
(3) Every written request for the release of information submitted pursuant to subrule (2) of this rule shall be signed by the person making the written request. Such signature shall comply with either of the following provisions:
(a) Be witnessed by an employee of the department who has been designated to witness such requests and to whom the person making the request presents suitable identification as required by subrule (4) of this rule.
(b) Be notarized by a notary public or magistrate.
(4) Any person who is required by subrule (2) or (3) of this rule to present suitable identification shall present an identification document, such as a driver's license, or other document which contains both a picture of the person and the signature or mark of the person.
(5) The director of the department may, pursuant to R 325.9055, release information from the cancer reporting system to an authorized representative of a study or research project reviewed by the scientific advisory panel and approved by the director. The department shall not release any part of a patient's medical record obtained pursuant to R 325.9053.

History: 1985 MR 4, Eff. May 2, 1985.

**R 325.9055 Scientific advisory panel; release of information for research.**
Rule 5. (1) The director of the department shall appoint a scientific advisory panel of not less than 3 scientists to review research proposals whereby a release of information maintained by the department which identifies an individual reported to have a diagnosis of cancer is required.
(2) All research proposals which require the release of information that identifies individuals with reported diagnoses of cancer shall be reviewed by the scientific advisory panel.
(3) The panel shall, in writing, advise the director concerning the merits of the study.
(4) The release of information for research which identifies individuals with reported diagnoses of cancer shall be subject to the terms and conditions set by the department. Such study or research project shall not publish the name of any individual who is or was the subject of a report of cancer submitted to the department, and such study or research project shall not release any identifying number, mark, or description which can be readily associated with an individual who is or was the subject of a report of cancer submitted to the department.
(5) A reporting entity shall, upon notification that the director has approved a research project, provide to the department or a researcher named by the director the name of the primary physician responsible for the medical care of persons selected for the research study as indicated in the reporting entity's records.

History: 1985 MR 4, Eff. May 2, 1985.

**R 325.9056 Exchange of records.**
Rule 6. The department, by agreement, may transmit transcripts or copies of reports of cancer diagnoses to state or national cancer registries when the reports relate to residents of other states or countries. The agreement shall require that the transcripts or records be used for statistical purposes only as specified in the agreement and that the identity of a person subject to the report shall not be released.

History: 1985 MR 4, Eff. May 2, 1985.

**R 325.9057 Adoption by reference.**
Rule 7. The publication entitled "International Classifications of Diseases for Oncology," 1976, specified in R 325.9051 is adopted by reference in these rules. Copies of the adopted matter may be obtained from the World Health Organization Publications Center, U.S.A., 49 Sheridan Avenue, Albany, NY 12210, or from the Department of Public Health, Box 30035, 3500 N. Martin Luther King, Jr. Blvd., Lansing, Michigan 48909. At the time of adoption of these rules the cost per copy is $10.00.

History: 1985 MR 4, Eff. May 2, 1985.

**R 325.971 Reporting of cancer.**
Rule 1. (1) On and after May 1, 1947, every physician, dentists, hospital superintendent, and clinic director who has knowledge of a case of cancer shall, within 10 days, report the same to the Michigan department of health on a form provided by said department. The report shall contain the name and address of the patient and either the name and address of the physician, or of the dentist, or of the hospital superintendent and hospital, or of the clinic director and clinic, and such other data as may be required.
(2) All such reports and records of the Michigan department of health pertaining to cancer are hereby declared to be confidential.

History: 1944 ACS 10. p. 16: 1954 AC. P. 2317.

Editor's note: This rule appears in the Michigan Administrative code of 1954 as R 325.975.

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## REPORTING FACILITY RESPONSIBILITIES

### A. Michigan Hospitals and Laboratories

1. Know the Michigan Cancer Surveillance Program rules for reporting.

2. Select a reporting option; whether on paper or electronic and establish a schedule for reporting (quarterly submissions are preferred). Notify the Michigan Cancer Surveillance Program of any changes in the method of reporting.

3. Perform all case finding activities to ensure completeness of reporting.

4. Information on reportable cases MUST be submitted to the Michigan Cancer Surveillance Program within six months or 180 days from the initial date of diagnosis. If there is a reporting problem please notify the Michigan Cancer Surveillance Program.

5. Inform the Michigan Cancer Surveillance Program of any changes in the contact person at your facility.

6. Facilities will be involved in periodic quality control visits by a quality improvement field representative from the Michigan Cancer Surveillance Program. These reporting facilities will be requested to do the following:

   -provide access to medical records as requested for quality review;
   -submit master disease index as requested for complete casefinding;
   -provide adequate work space for field representative;
   -provide access to pathology, radiation, and chemotherapy records for complete casefinding;
   -be available for consultation in quality control reviews.

7. Maintain some type of accession log or master file of submissions which will serve as a quick reference of all cases sent to the Michigan Cancer Surveillance Program. This may be as simple as keeping copies of the cancer report forms or maintaining a reporting log which includes name, primary site, date of diagnosis, and date case was sent to the state.

8. Download and print the following manuals to use when completing the cancer report form:

   Collaborative Stage Data Collection System Manual (CSv02.03) at
   http://www.cancerstaging.org/cstage/manuals.html

   SEER Multiple Primary and Histology Coding Rules at
   http://seer.cancer.gov/tools/mphrules/2007_mphrules_manual_04302008.pdf

   SEER Summary Staging Manual at http://seer.cancer.gov/tools/ssm/ AND
   Staging Manual corrections http://seer.cancer.gov/tools/ssm/errata_08202002.pdf

   Definitions of Single and Subsequent Primaries for Hematologic Malignancies at
   http://seer.cancer.gov/icd-o-3/hematopoietic_primaries.d03152001.pdf

   Site/Histology Validation List at www.seer.cancer.gov.icd-o-3/

Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic and Lymphoid Neoplasms Database at http://seer.cancer.gov/tools/heme/

SEER*Rx - Interactive Antineoplastic Drugs Database at http://seer.cancer.gov/tools/seerrx/

9. Purchase the International Classification of Diseases for Oncology, Third Edition (ICD-O-3) from World Health Organization's North American distributor, WHO Publications Center USA, 49 Sheridan Avenue, Albany, NY 12210. WHO has set the price for single copies of ICD-O-3 at $54.00.

   For ICD-O-3 errata and clarifications go to:
   http://www.who.int/classifications/icd/updates/ICD-O-3-errata.d05222001.pdf
   AND
   http://www.who.int/classifications/icd/updates/ICD-O-3-errata.d05062003.pdf

## B. Responsibilities of the Michigan Cancer Surveillance Program

1. Provide to all reporting facilities all cancer report forms.

2. Provide training and ability to locate reference materials through the world wide web and agencies.

3. Perform all computer data entry of manually submitted reports and process patient data updates.

4. Conduct procedures to un-duplicate the cancer patient file, to edit the file following accepted cancer editing standards and to clarify and resolve issues relative to data quality that are encountered.

5. Provide specific reports to verify data submission as requested by the reporting facility.

6. Release a statistical report, Cancer Incidence and Mortality, annually and have available on the web at http://www.michigan.gov/mdch, (click on Statistics and Reports, then on Cancer Statistics to see the report).

## PREPARATION OF THE CANCER REPORT FORMS

Whenever a cancer case is diagnosed or first treated within a hospital or laboratory, a report of the case must be prepared and forwarded to the Michigan Cancer Surveillance Program. The report must be sent within 180 days or six months from the initial date of diagnosis or initial treatment. The form to use in reporting a cancer case is the Cancer Report DCH-0768 (Rev. 3/2010). Proper completion of this form is an important ingredient to the development of a cancer registry for the state. These instructions are intended to outline what information is needed and to provide specific guidance for completing the form. Should the instructions need clarification or if special problems exist which make reporting as outlined difficult, do not hesitate to contact the office to discuss the matter.

Specific instructions for identifying cases, determining primary site, assigning histology and stage is discussed in great detail in sections to follow.

## REPORTING INSTRUCTIONS

Upon reaching a diagnosis of an in situ or invasive cancer or providing treatment for a patient diagnosed elsewhere, a hospital or laboratory is to report the case. In addition, any tumor diagnosed October 1, 2004 or later with a behavior code of '0' or '1' for the following site codes: meninges (C70.0 – C70.9); brain (C71.0 – C71.9); spinal cord, cranial nerves, and other parts of the central nervous system (C72.0 – C72.9); pituitary gland (C75.1); craniopharyngeal duct (C75.2); and pineal gland (C75.3) must be reported. ***The report must be on a form provided by the department and submitted within 180 days or six months from the initial date of diagnosis*.**

Generally, each primary cancer which is diagnosed or treated within a hospital or laboratory should be reported to the office on a separate cancer report form. The diagnosis and/or treatment of a patient for a primary tumor that was previously reported by the facility need not be reported a second time. Revisions and corrections to previously submitted information is important, however. New primary tumors diagnosed in previously reported patients are reportable.

As reports are received by the department, they will be reviewed, queried, electronically recorded and edited. In the course of assembling the data into a registry, duplicate reports of primary tumor diagnoses will be identified and tagged. The resultant file can thereby be utilized to develop accurate incidence information. There will be no active follow-up on the status or treatment of reported cases. Rather, a tumor incidence registry is intended. Only follow-up for quality control and specific research projects will occur.

The use of acceptable case finding and record abstracting procedures are essential to complete reporting. The basic elements of reporting are good case finding, the proper identification of cases that are reportable, proper preparation of reports, and prompt submission of the reports.

Because the state maintains an incidence registry only, the information required for the state cancer report is limited when compared to a typical hospital cancer registry. The reporting of annual follow-up information on the status of a case is not necessary. However, if the patient becomes deceased, the vital status must be reported. What are required are basic items of information which identify and describe the patient and which relate to the reportable conditions that have been diagnosed for that patient. Information on the types of therapy provided as the first course of therapy is also required. The instructions which follow are organized to correspond with the order of the items on the cancer report form.

The cancer report form may be completed by typing or printing. The form may also be photocopied when your supply is low. Be sure to maintain legibility when making copies.

During internal quality control reviews, the following essential data items are the most common problem areas and are routinely queried for clarification.

| | |
|---|---|
| Patient's first name | blank, inconsistent, unknown or illegible |
| Patient's last name | blank, unknown or illegible |
| Complete address | blank, illegible or inconsistent |
| Sex | blank, inconsistent with name or site |
| Date of Birth | blank, inconsistent with site, report date, or date of diagnosis |
| Social Security Number | blank |
| Primary site | blank or inconsistent with histology |
| Laterality | blank and a paired organ is reported for the primary site |
| Histology | blank, if inconsistent with the primary site or if it indicates the condition may not be reportable |
| Stage | inconsistent with histology, blank, or invalid values based upon specific staging system |
| Method of diagnosis | blank or inconsistent as in an in situ diagnosis not based upon a microscopic method of diagnosis |
| Treatment | blank and the report is from a hospital with a treatment center |

If the reporting facility cannot supply the needed data items requested, the next step is to query the attending physician. For such cases, the complete name and office address of the physician is requested.

For independent laboratories that do not have access to necessary patient demographic information to complete the report, adding the name and office address of the doctor to the report is extremely helpful. This reference information on the physician should be added to the bottom of the cancer report form for any case with missing information. Be sure to supply the doctor's full name and complete mailing address.

**Manual Submission**
Cases submitted manually, must use the current revision DCH-0768 (Rev. 3/2010) and ***submitted within 180 days of the diagnosis.***

The cancer report form is available in Publisher and as an Adobe Acrobat PDF file. This electronic copy of the cancer report form may be used in lieu of the actual paper form which is supplied by the MCSP office. For an electronic copy of the cancer report form, please contact staff at the MCSP office or visit www.michigan.gov/mdch; clicking providers, departmental forms, cancer reporting forms.

A report for each separate primary tumor is required.

Additional reports for subsequent re-diagnosis or additional treatments of a previously reported condition are NOT required.

**Mail completed cancer report forms to:**
Michigan Cancer Surveillance Program
Vital Records & Health Data Development Section
P.O. Box 30691
Lansing, MI 48909
*Attention: Elaine Snyder*

**Electronic Submission:**
Cases submitted electronically are encouraged to be submitted in the most recent version of the data exchange format and code structures as specified by the North American Association of Central Cancer Registries (NAACCR). NAACCR Version 12 Reporting Format begins with 2010 diagnoses.

Facilities having tumor registries that utilize computer software may elect to submit cancer reports electronically. A diskette, CD or FTP site may be used to transmit reports to the Michigan Cancer Surveillance Program. This section covers information needed by a reporting facility that wishes to submit cancer reports through electronic/automated methods. Hospitals with tumor registries are the most likely candidates to elect this method of transmission. Hospitals may choose from a variety of commercially available software and varying modes of data transmission. Tumor registries electing to use commercially available software have a choice of tumor registry programs from which to select. These software programs are usually amenable to easy transmission of data to the Michigan Cancer Surveillance Program.

These software programs include Metriq and OncoLog.

Effective July 1, 2007, the MCSP will expect those facilities with 100 cases or more a year, to have Abstract Plus (abstracting software provided free of charge by the MCSP) installed. High volume facilities will no longer be permitted to submit their cases on paper.

For Abstract Plus support such as abstract plus installation, FTP site issues, password reset or other related technical difficulties, please contact **Terry Mc Taggart** at **mctaggart@michigan.gov** or **(517) 335-9624**.

**Mail diskettes to:**
Michigan Cancer Surveillance Program
Vital Records & Health Data Development Section
P.O. Box 30691
Lansing, MI 48909
*Attention: Wendy Stinnett*

**Submitting Corrections**
If a cancer case is reported, and later determined *not* to be reportable, *OR* the information to resolve an unknown variable has been obtained *OR* the information for a particular variable was later determined to be submitted incorrectly, a correction to the previously submitted report MUST be forwarded. It is especially important to send corrections when there are changes in the date of diagnosis, primary site, histology, tumor grade, stage, etc. To submit a correction, please conduct the following:

Manual Submission

1. Copy the **original** cancer report form that was submitted.
2. Draw a line through the INCORRECT information.
3. Pencil in and **HIGHLIGHT** the corrected information.
4. Check UPDATE in the upper right hand corner
5. Mail corrected case(s) to Elaine Snyder (see address above.)

Electronic Submission

1. Use NAACCR field 10 Record Type, to identify that an UPDATE or CORRECTION has been made.
2. Record a "M" to indicate that the record has been modified and previously submitted to the central registry.
3. Submit the corrected case(s) on a diskette.
4. Mail diskettes to Wendy Stinnett (see address above.)

*OR*

1. Use NAACCR field 2220 State/Requestor Items, to identify that the record contains corrected information.
2. Record a "2" as the first value in the field to indicate an UPDATE or CORRECTION has taken place.
3. Submit the corrected case(s) on a diskette.
4. Mail diskettes to Wendy Stinnett (see address above.)

NOTE: Do NOT use the NAACCR Update /Correction Layout Version 2.0 to submit corrections.

*OR*

Print the abstract that coincides with the patient's corrected information.
**HIGHLIGHT** the corrected information.
Indicate the original date the case was submitted.
Mail abstract to Elaine Snyder (see address above.)

**Text Documentation**

Text may be needed to justify the codes selected for the data items and to allow recording information that is not coded at all. It is a component of a complete electronic abstract, and allows for the full abstract to be printed or reviewed on the screen as needed. In addition, the text is used for quality control and special studies. As the purpose of text information is to provide the opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values. When the supporting text information is printed for review, one should be able to re-abstract the case without obtaining additional medical records and have the same codes as the original abstract. If there is no information for a particular text field, you may NOT leave the data item. Record 'n/a' or 'none' in the text field when there is no information available. This documentation confirms that information was searched for and no information exists. **Please note, submission of data without text documentation may be rejected by the MCSP in its entirety!**

**Reporting Requirements by Item and Facility Type - 2011**
Specific reporting requirements for hospitals operating a cancer registry, hospitals with no cancer registry and independent laboratories are summarized in the table below. The need to report an item has been assigned to the levels of required, reportable, and not required. These requirements are patterned after the ACoS levels for inclusion of information within a hospital registry. The practical definitions of these levels of reportability are best termed as levels of effort associated with collecting and providing the information. If there is no information available, and inquires have been made, do not leave the item blank (unless specifically noted in the individualized data item instructions ie: family history of cancer), record the appropriate NOS or default code.

| | |
|---|---|
| [**REQ**]<br>Required | The facility **must** collect and report the information with data collection efforts including review of the patient's hospital charts, outpatient records or other available records, as well as making inquiries with other facilities or the physician on record as is necessary to obtain the information.<br><br>NOTE: For instructions on how to code missing information, refer to the applicable coding manual for that data item. |
| [**REP**]<br>Reportable | The facility **must** report the information if it can be located within the patient's chart, outpatient records or other available records, but need not make inquiries of other facilities or physician's offices. |
| [**N/R**]<br>Not/Required | Item considered generally not available to the facility and/or not considered as reliably available. Information may be reported if available to the facility. |

**Special Site Specific Factor Field Requirements:**
The site specific factor field requirements are modeled after the requirements set forth by the American College of Surgeons. A color coded spreadsheet has been created indicating which SSF fields are required. Those SSF fields highlighted in blue will be REQUIRED or REPORTABLE based upon facility type. Refer to the facility types listed below for specific requirements.

Refer to the CoC and SEER Required Site-Specific Factors (SSF) for Collaborative Staging Version 02.03 spreadsheet located at http://seer.cancer.gov/tools/ssf/alpha_order.pdf for a complete listing of the SSF fields highlighted in blue.

***Hospital with a Registry:***
The SSF fields with an highlighted in blue are REQUIRED for hospitals with a registry. In other words, if the information is not available in the medical record, you are required to make inquires to find the information.

If the SSF field is NOT highlighted in blue, then the item is REPORTABLE for a hospital with a registry. Meaning, if the information is in the medical record, you are required to report it; however if the information is not in the medical record, you do NOT need to make inquires to locate the information.

If there is no information available, and inquires have been made, do not leave the item blank, refer to the CSv02.03 manual for the correct default codes.

***Hospital without a Registry:***
ALL of the SSF fields are REPORTABLE for a hospital without a registry, regardless of

whether or not the fields are highlighted in blue. Meaning, if the information is in the medical record, you are required to report it; however if the information is not in the medical record, you do not need to make inquires to locate the information.

If there is no information available, do not leave the item blank, refer to the CSv02.03 manual for the correct default codes.

***Independent Laboratories:***
The SSF fields are NOT required, or reportable for laboratories, however, do not leave the item blank, refer to the CSv02.03 manual for the correct default codes.

**Facility Type**
When two facilities with different reporting requirement levels coordinate reporting responsibilities, the requirements for reporting are determined by the facility with the highest reporting level. For example, should a laboratory and a hospital with a registry agree to share reporting responsibilities, the reporting requirement to meet would be of a 'hospital with a registry.'

Once you have determined your facility type, use the table on the following pages to determine the level of reporting requirement for each data item. The definitions for the three facility types are as follows:

1. Hospital with a Registry - an entity that has an approved cancer program by the American College of Surgeons (ACoS) or *working* towards ACoS approval *or* a regional registry that houses data for surrounding facilities.

2. Hospital without a Registry - geared towards smaller entities that do not have an approved cancer program *or* have limited resources to diagnosis and treat cancer patients.

3. Independent Laboratories - a separate laboratory from a hospital that reads specimens for either a hospital or physician's office.

| *Item Number* | *Item Name* | *NAACCR Item* | *Hospital w/ Registry* | *Hosp w/o Registry* | *Independent Laboratory* |
|---|---|---|---|---|---|
| 1a | Last Name of Patient | 2230 | REQ | REQ | REQ |
| 1b | First Name of Patient | 2240 | REQ | REQ | REQ |
| 1c | Middle Name of Patient | 2250 | REQ | REQ | REQ |
| 2 | Maiden Name | 2390 | REP | REP | N/R |
| 3 | Alias Name | 2280 | REP | REP | N/R |
| 4 | Social Security Number | 2320 | REQ | REQ | REQ |
| 5a | Patient Address at Time of Diagnosis (Number & Street) | 2330 | REQ | REQ | REQ |
| 5b | City at Diagnosis | 70 | REQ | REQ | REQ |
| 5c | Supplemental Address at Diagnosis | 2335 | REQ | REQ | REQ |
| 5d | State at Diagnosis | 80 | REQ | REQ | REQ |

| *Item Number* | *Item Name* | *NAACCR Item* | *Hospital w/ Registry* | *Hosp w/o Registry* | *Independent Laboratory* |
|---|---|---|---|---|---|
| 5e | Zip Code at Diagnosis | 100 | REQ | REQ | REQ |
| 6 | County at Diagnosis | 90 | REQ | REQ | REQ |
| 7 | Date of Birth | 240 | REQ | REQ | REQ |
| 8 | Birthplace | 250 | REP | REP | N/R |
| 9 | Sex | 220 | REQ | REQ | REQ |
| 10 | Spanish/Hispanic Origin | 190 | REQ | REQ | REP |
| 11 | Race | 160-164 | REQ | REQ | REQ |
| 12 | Marital Status at Diagnosis | 150 | REP | REP | REP |
| 13 | Primary Payer at Diagnosis | 630 | REQ | REQ | REP |
| 14 | Comorbid/Complication (ICD-9-CM Codes) | 3110-3164 | REQ | REQ | N/R |
| 15a | Usual Occupation Prior to Retirement | 310 | REP | REP | N/R |
| 15b | Usual Industry Prior to Retirement | 320 | REP | REP | N/R |
| 16a-c | Family History of Cancer | 360/9520 | REP | REP | N/R |
| 17 | Alcohol Use | 350/9521 | REP | REP | N/R |
| 18 | Tobacco Use | 340/9522 | REP | REP | N/R |
| 19 | Medical Record Number | 2300 | REQ | REQ | N/R |
| 20 | Laboratory Report Number | 9507 | REP | REP | REQ |
| 21 | Accession Number and Sequence Number | 550/560 | REQ | N/R | N/R |
| 22 | Type of Reporting Source | 500 | REQ | REQ | REQ |
| 23 | Case Finding Source | 501 | REQ | REQ | REQ |
| 24 | Reporting Facility and City | 540 | REQ | REQ | REQ |
| 25 | Michigan Facility Number | 9508 | REQ | REQ | REQ |
| 26 | Class of Case | 610 | REQ | REQ | REQ |
| 27a | Date of Inpatient Admission | 590 | REQ | REQ | N/R |
| 27b | Date of Inpatient Admission Flag | 591 | REQ | REQ | N/R |
| 28a | Date of Inpatient Discharge | 600 | REQ | REQ | N/R |

| *Item Number* | *Item Name* | *NAACCR Item* | *Hospital w/ Registry* | *Hosp w/o Registry* | *Independent Laboratory* |
|---|---|---|---|---|---|
| 28b | Date of Inpatient Discharge Flag | 601 | REQ | REQ | N/R |
| 29 | Date of First Contact | 580 | REQ | REQ | N/R |
| 30 | Date of Diagnosis | 390 | REQ | REQ | REQ |
| 31 | Primary Anatomical Site | 400/2580 | REQ | REQ | REQ |
| 32 | Laterality (Paired Organ) | 410 | REQ | REQ | REQ |
| 33a | Histology | 2570/522/2590 | REQ | REQ | REQ |
| 33b | Behavior Code | 523 | REQ | REQ | REQ |
| 34 | Grade/Differentiation | 440 | REQ | REQ | REQ |
| 35 | Grade Path System | 449 | REQ | REQ | REQ |
| 36 | Grade Path Value | 441 | REQ | REQ | REQ |
| 37 | Lymph Vascular Invasion (LVI) | 1182 | REQ | REQ | REP |
| 38 | Diagnostic Confirmation | 490 | REQ | REQ | REQ |
| 39 | SEER Summary Staging 2000 | 759 | REQ | REQ | REQ |
| 40 | AJCC Stage: Clinical T | 940 | REQ | REP | N/R |
| 40 con't | AJCC Stage: Clinical N | 950 | REQ | REP | N/R |
| 40 con't | AJCC Stage: Clinical M | 960 | REQ | REP | N/R |
| 40 con't | AJCC Clinical TNM Stage Group | 970 | REQ | REP | N/R |
| 40 con't | AJCC Clinical TNM Descriptor | 980 | REQ | REP | N/R |
| 40 con't | AJCC Stage: Pathological T | 880 | REQ | REP | N/R |
| 40 con't | AJCC Stage: Pathological N | 890 | REQ | REP | N/R |
| 40 con't | AJCC Stage: Pathological M | 900 | REQ | REP | N/R |
| 40 con't | AJCC Pathological TNM Stage Group | 910 | REQ | REP | N/R |
| 40 con't | AJCC Pathological TNM Descriptor | 920 | REQ | REP | N/R |
| 41 | CS Tumor Size | 2800 | REQ | REQ | REP |
| 42 | CS Extension | 2810 | REQ | REQ | N/R |
| 43 | CS Tumor Size/Ext Eval | 2820 | REQ | REQ | N/R |
| 44 | CS Lymph Nodes | 2830 | REQ | REQ | N/R |

| *Item Number* | *Item Name* | *NAACCR Item* | *Hospital w/ Registry* | *Hosp w/o Registry* | *Independent Laboratory* |
|---|---|---|---|---|---|
| 45 | CS Lymph Nodes Eval | 2840 | REQ | REQ | N/R |
| 46 | Regional Lymph Nodes Examined | 820 | REQ | REQ | N/R |
| 47 | Regional Lymph Nodes Positive | 830 | REQ | REQ | N/R |
| 48 | CS Metastasis at Diagnosis | 2850 | REQ | REQ | N/R |
| 49 | CS Mets Bone | 2851 | REQ | REQ | N/R |
| 50 | CS Mets Brain | 2852 | REQ | REQ | N/R |
| 51 | CS Mets Liver | 2853 | REQ | REQ | N/R |
| 52 | CS Mets Lung | 2854 | REQ | REQ | N/R |
| 53 | CS MetsEval | 2860 | REQ | REQ | N/R |
| 54 | Site-Specific Factor (SSF) 1 | 2880 | Refer to special SSF requirements listed above | | N/R |
| 55 | SFF2 | 2890 | Refer to special SSF requirements listed above | | N/R |
| 56 | SSF3 | 2900 | Refer to special SSF requirements listed above | | N/R |
| 57 | SSF4 | 2910 | Refer to special SSF requirements listed above | | N/R |
| 58 | SSF5 | 2920 | Refer to special SSF requirements listed above | | N/R |
| 59 | SSF6 | 2930 | Refer to special SSF requirements listed above | | N/R |
| 60 | SSF7 | 2861 | Refer to special SSF requirements listed above | | N/R |
| 61 | SSF8 | 2862 | Refer to special SSF requirements listed above | | N/R |
| 62 | SSF9 | 2863 | Refer to special SSF requirements listed above | | N/R |
| 63 | SSF10 | 2864 | Refer to special SSF requirements listed above | | N/R |
| 64 | SSF11 | 2865 | Refer to special SSF requirements listed above | | N/R |
| 65 | SSF12 | 2866 | Refer to special SSF requirements listed above | | N/R |
| 66 | SSF13 | 2867 | Refer to special SSF requirements listed above | | N/R |
| 67 | SSF14 | 2868 | Refer to special SSF requirements listed above | | N/R |
| 68 | SSF15 | 2869 | Refer to special SSF requirements listed above | | N/R |
| 69 | SSF16 | 2870 | Refer to special SSF requirements listed above | | N/R |
| 70 | SSF17 | 2871 | Refer to special SSF requirements listed above | | N/R |

| *Item Number* | *Item Name* | *NAACCR Item* | *Hospital w/ Registry* | *Hosp w/o Registry* | *Independent Laboratory* |
|---|---|---|---|---|---|
| 71 | SSF18 | 2872 | Refer to special SSF requirements listed above | | N/R |
| 72 | SSF19 | 2873 | Refer to special SSF requirements listed above | | N/R |
| 73 | SSF20 | 2874 | Refer to special SSF requirements listed above | | N/R |
| 74 | SSF21 | 2875 | Refer to special SSF requirements listed above | | N/R |
| 75 | SSF22 | 2876 | Refer to special SSF requirements listed above | | N/R |
| 76 | SSF23 | 2877 | Refer to special SSF requirements listed above | | N/R |
| 77 | SSF24 | 2878 | Refer to special SSF requirements listed above | | N/R |
| 78 | SSF25 | 2879 | Refer to special SSF requirements listed above | | N/R |
| 79 | Treatment Summary – Treatment Status | 1285 | REQ | REQ | N/R |
| 80a | Date First Course of Treatment | 1270 | REQ | REQ | N/R |
| 80b | Date First Course of Treatment Flag | 1271 | REQ | REQ | N/R |
| 81 | Systemic/Surgery Sequence | 1639 | REQ | REQ | N/R |
| 82 | Reason for No Surgery of Primary Site | 1340 | REQ | REQ | N/R |
| 83a | Date First Surgical Procedure | 1200 | REQ | REQ | N/R |
| 83b | Date First Surgical Procedure Flag | 1201 | REQ | REQ | N/R |
| 84 | Surgical Procedure of Primary Site Code | 1290/2560/2610 | REQ | REQ | N/R |
| 85 | Surgical Procedure/Other Site | 1294 | REQ | REQ | N/R |
| 86 | Scope of Regional Lymph Node Surgery | 1292 | REQ | REQ | N/R |
| 87 | Radiation/Surgery Sequence | 1380 | REQ | REQ | N/R |
| 88a | Date Radiation Started | 1210 | REQ | REQ | N/R |
| 88b | Date Radiation Started Flag | 1211 | REQ | REQ | N/R |
| 89 | Reason No Radiation | 1430 | REQ | REQ | N/R |
| 90 | Radiation Treatment Modality | 1570 | REQ | REQ | N/R |
| 91a | Date Chemotherapy Started | 1220 | REQ | REQ | N/R |
| 91b | Date Chemotherapy Flag | 1221 | REQ | REQ | N/R |
| 92 | Chemotherapy | 1390 | REQ | REQ | N/R |

| *Item Number* | *Item Name* | *NAACCR Item* | *Hospital w/ Registry* | *Hosp w/o Registry* | *Independent Laboratory* |
|---|---|---|---|---|---|
| 93 | Hematologic Transplant and Endocrine Procedures | 3250 | REQ | REQ | N/R |
| 94a | Date Hormone Started | 1230 | REQ | REQ | N/R |
| 94b | Date Hormone Started Flag | 1231 | REQ | REQ | N/R |
| 95 | Hormone Therapy | 1400 | REQ | REQ | N/R |
| 96a | Date Immunotherapy Started | 1240 | REQ | REQ | N/R |
| 96b | Date Immunotherapy Started Flag | 1241 | REQ | REQ | N/R |
| 97 | Immunotherapy | 1410 | REQ | REQ | N/R |
| 98a | Date Other Therapy Started | 1250 | REQ | REQ | N/R |
| 98b | Date Other Therapy Started Flag | 1251 | REQ | REQ | N/R |
| 99 | Other Treatment | 1420 | REQ | REQ | N/R |
| 100a | Date of Last Contact | 1750 | REQ | REQ | N/R |
| 100b | Date of Last Contact Flag | 1751 | REQ | REQ | N/R |
| 101 | Text<br>Physical Exam/Signs & Symptoms/Lab Results | 2520/2550 | REQ | REQ | REQ |
| 102 | Text<br>X-rays/Scans | 2530 | REQ | REQ | N/R |
| 103 | Text<br>Biopsy/Scopes/Staging/Path | 2540/2570/2600 | REQ | REQ | REQ |
| 104 | Text<br>Chemo/Hormone/Immunotherapy/Other | 2640/2650/2660/ 2670 | REQ | REQ | N/R |
| 105 | Text<br>Radiation Therapy/Miscellaneous | 2620/2680 | REQ | REQ | N/R |
| 106 | Abstractor Name and Contact Number | 570/--- | REQ | REQ | REQ |
| 107 | Vital Status | 1760 | REQ | REQ | REQ |
| 108 | Date of Death | 1750 | REQ | REP | N/R |
| 109 | Death Cause | 1910 | REQ | REP | N/R |
| 110 | Death State | 1940 | REQ | REP | N/R |
| 111 | Date Abstracted | 2090 | REQ | REQ | REQ |

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**Specific Instructions for Completing Each Item on the Cancer Report Form**

In describing the proper reporting of cancer patient information, reference will frequently be made to standard reference sources. These reference sources are abbreviated within the instructions as follows:

| | |
|---|---|
| SEER | Surveillance, Epidemiology and End Results |
| COC | Commission on Cancer within the American College of Surgeons |
| ACoS | American College of Surgeons |
| FORDS | *Facility Oncology Registry Data Standards* manual produced by the COC |
| NAACCR | North American Association of Central Cancer Registries |
| AJCC | American Joint Committee on Cancer |
| ICD-O-3 | *International Classification of Diseases for Oncology, Third Edition* |
| CSv02.03 | Collaborative Stage Data Collection System Manual (CSv02.03) |

Item 1. Name of Patient (Item 1a, 1b, 1c)

Enter the legal name of the patient.

Do not abbreviate.

If only an initial is available for the middle name, enter the initial.

If the name is unknown, as in the case of an unidentified body diagnosed at an autopsy, enter "unknown."

Item 2. Maiden Name

Leave this item blank if it is not appropriate for the patient being reported, is not available in the records, or when not reporting this item.

Item 3. Alias Name

Enter an alternate name or AKA (also known as) used by the patient, if known.

Item 4. Social Security Number

Enter the social security number of the patient. If the patient does not have a social security number, enter "999-99-9999."

If this number cannot be ascertained, enter "999-99-9999."

If the social security number ends with "B" or "D" record as "999-99-9999." The patient is receiving benefits under the spouse's number and this is the spouse's social security number.

Item 5a. Patient Address at Time of Diagnosis (Number and Street)

Enter the street address of the patient's usual residence at the ***initial time of diagnosis***. The address does NOT change if the patient moves.

The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards.

If the patient has more than one primary tumor, the address at diagnosis may be different for each primary.

If a rural route number or post office box is given, this can be recorded, but ONLY if the street and numbers are NOT available. In abbreviating street and place names, use standard U.S. Postal abbreviations.

If the address is unknown, enter "unknown."

Item 5b. City at Diagnosis

Enter the postal city, village or town in which the patients resides at the time of diagnosis.

If the city is unknown, enter "unknown."

If the patient has more than one primary tumor, the city at diagnosis may be different for each primary.

Item 5c. Supplemental Address at Diagnosis (Nursing Home, Apt Complex)

Record the name of a place or facility (i.e. nursing home, name of an apartment complex) at the time of diagnosis.

Item 5d. State at Diagnosis

Enter the state of residence for the patient at the time of diagnosis.

Codes other than United States:

| | |
|---|---|
| CD | Resident of Canada, NOS (province/territory unknown) |
| US | Resident of United States, NOS (state/commonwealth/territory/possession unknown) |
| XX | Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known |
| YY | Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown |
| ZZ | Residence unknown |

NOTE: Reports on Michigan residents, as well as nonresidents is required.

Item 5e. Zip Code at Diagnosis

Record the patient's five or nine digit postal code at the time of diagnosis.

If the zip code is unknown, enter "99999" or "999999999."

Item 6. County at Diagnosis

Enter the name of the county of the patient's residence at the time of diagnosis.

If the county is not obtainable, enter "unknown."

Item 7. Date of Birth

Enter date of birth of the patient using **CCYY/MM/DD** (*for example 1958/09/12*) as the format.

If age at diagnosis and year of diagnosis are known, but year of birth is unknown, then year of birth should be calculated and so coded.

Estimate date of birth when information is not available. It is better to estimate than to leave birthdate unknown.

If date of birth is unknown, but an age at time of diagnosis is available, enter the patient's age.

Item 8. Birth Place - State or Country

Enter the patient's place of birth.

If the information is not available in the patient's record, leave the item blank.

Item 9. Sex

Record the sex of the patient by entering the corresponding code.

The codes are as follows:
1 - Male
2 - Female
3 - Other (hermaphrodite)
4 - Transsexual
9 - Not Stated/Unknown

Item 10. Spanish/Hispanic Origin

Indicate whether the patient is of Hispanic origin, by entering the number which corresponds to their status, as is indicated on the form.

It is better to record '0- Non-Spanish, Non-Hispanic' when there is no documentation of Hispanic decent rather than recording unknown.

Independent laboratories are not expected to report this item and may leave the item blank, otherwise **do not leave this item blank.**

Codes are as follows:
0 - Non-Spanish; Non-Hispanic
1 - Mexican (includes Chicano)
2 - Puerto Rican
3 - Cuban
4 - South or Central American (except Brazil)
5 - Other specified Spanish/Hispanic origin
6 - Spanish, NOS; Hispanic NOS; Latino NOS
7 - Spanish surname ONLY
8 - Dominican Republic
9 - Unknown whether Spanish or not

Item 11. Race

Enter the patient's race according to the documentation in the medical record.

If multi-racial, enter each race according to the documentation in the patient's chart, for a total of five races.

In general, race should be reported as American Indian, white, black, etc.

White includes Mexican, Puerto Rican, Cuban, and all other Caucasians.

If Asian, enter the national origin as Chinese, Vietnamese, Japanese, Hmong, etc.

Race is a required data item for all facilities regardless of the facility type. If the patient's race is not available in the medical record, it may be necessary to contact the physician's office.

For manual submission, the codes are not necessarily required, but have been provided to assist with identifying the appropriate race.

The codes are as follows:
01 - White
02 - Black
03 - American Indian, Aleutian, or Eskimo
(includes all indigenous populations of the Western hemisphere)
04 - Chinese
05 - Japanese
06 - Filipino
07 - Hawaiian
08 - Korean
**09 - Code retired; do not use.**
10 - Vietnamese
11 - Laotian
12 - Hmong
13 - Kampuchean (Cambodian)
14 - Thai

15 - Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16 - Asian Indian
17 - Pakistani
20 - Micronesian, NOS
21 - Chamorran
22 - Guamanian, NOS
25 - Polynesian, NOS
26 - Tahitian
27 - Samoan
28 - Tongan
30 - Melanesian, NOS
31 - Fiji Islander
32 - New Guinean
88 - No further race documented
96 - Other Asian, including Asian, NOS and Oriental, NOS
97 - Pacific Islander, NOS
98 - Other
99 - Unknown

Item 12. Marital Status

Enter the marital status of the patient at time of diagnosis.

The codes are as follows:
1 - Single (never married)
2 - Married
3 - Separated
4 - Divorced
5 – Widowed
6 – Unmarried or Domestic Partner
9 - Unknown

Item 13. Primary Payer at Diagnosis

Enter primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

Codes are as follows:
01 - Not insured
02 - Not insured, self-pay
10 - Insurance, NOS
20 - Private Insurance: Managed care, HMO, or PPO
21 - Private Insurance: Fee-for-Service
31 - Medicaid
35 - Medicaid - Administered through a Managed Care plan
60 - Medicare/Medicare, NOS
61 - Medicare with supplement, NOS
62 - Medicare - Administered through a Managed Care plan
63 - Medicare with private supplement
64 - Medicare with Medicaid eligibility
65 – TRICARE

66 - Military
67 - Veterans Affairs
68 - Indian/Public Health Service
99 - Insurance status unknown

Item 14. Co-morbidities/Complications (ICD-9-CM codes)

Co-morbidities are pre-existing medical conditions or conditions that were present at the time the patient was diagnosed with this cancer (e.g. chronic conditions such as COPD, diabetes, and hypertension).

Enter the patient's pre-existing medical conditions during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes.

The following codes are reportable co-morbidities:

**001–139.8**
**240–999.9**
**E870–E879.9**
**E930–E949.9**
**V07.2–V07.39**
**V10–V15.9**
**V22.2–V23.1**
**V25.4**
**V44–V45.89**
**V50.41–V50.49**

Do NOT review the medical record and assign codes to these conditions; you can only record the above conditions if they have been identified by the medical records coder and appear on the face sheet.

Co-morbid conditions are identified by ICD-9-CM codes **001–139.8 and 240–999.9**.

Complications are conditions that occur during the hospital stay, while the patient is being treated for the cancer (e.g. postoperative urinary tract infection or pneumonia). Complications may also occur following the completion of therapy and be a cause for readmission to the hospital. Complications are identified by the ICD-9-CM "E" codes which classify environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects.

Only "E" codes that describe adverse effects occurring during medical care are collected in this data item. They are represented by ICD-9-CM codes **E870–E879.9** (misadventures to patients during surgical and medical care) and **E930–E949.9** (drugs and medicinal and biologic substances causing adverse effects in therapeutic use).

Factors influencing the health status of patients are circumstances or problems that are not themselves a current illness or injury and are identified by the ICD-9-CM "V" codes (e.g. women receiving post menopausal hormone replacement therapy, or a history of malignant neoplasm).

Only specific "V" codes which describe health characteristics are collected in this data item. They are represented by ICD-9-CM codes **V07.2–V07.39** (prophylactic measures), **V10–V15.9**

(personal health history), **V22.2–V23.1** (pregnancy), **V25.4** (contraception), **V44–V45.89** (artificial opening and other post surgical states), **V50.41–V50.49** (prophylactic organ removal).

Item 15a. Patient's Occupation Prior to Retirement

Enter the usual occupation of the patient. "Usual Occupation" is the kind of work the patient did during most of his/her working life before retirement. Ie: claim adjuster, farm hand, coal miner, janitor, store manager, research chemist, civil engineer, college professor, teacher, etc.

Enter "student" if the patient was a student at the time of diagnosis and was never regularly employed.

This data item applies only to patient's who are 14 years of age or older at the time of diagnosis.

Do not use "retired." If the patient has retired from his or her usual occupation, the "usual occupation and business/industry" of the patient must be specified.

If the patient was never employed enter "never employed."

If the usual occupation of the patient is unknown, enter "unknown."

If the patient was a homemaker at the time of diagnosis, but had worked outside the household during his or her working life, enter that occupation.

If the patient was a homemaker during most of his or her working life, and never worked outside the household, enter "homemaker."

"Self-employed" by itself is incomplete. The kind of work must be determined. The entry for business/industry should include both the proper business/industry and the entry "self-employed."

Refer to *A Cancer Registrar's Guide to Collecting Industry and Occupation* to assist with coding this data item. The guide can be downloaded at http://www.cdc.gov/niosh/docs/2011-173/ and has been provided by CDC.

Item 15b. Usual Industry Prior to Retirement

Code the patient's industry based upon their usual occupation before retirement.

Enter the kind of business or industry to which the occupation in Item 15a was related, such as insurance, automobile, government, school, church, etc.

Do NOT enter organization or firm names.

If the patient was never employed, enter "never employed."

If this information is unknown, enter "unknown."

Refer to *A Cancer Registrar's Guide to Collecting Industry and Occupation* to assist with coding this data item. The guide can be downloaded at http://www.cdc.gov/niosh/docs/2011-173/ and has been provided by CDC.

Item 16a. Family History of Cancer

Enter whether or not the patient has a family history of cancer.
If unknown, leave **BLANK**.

Item 16b. If yes, Immediate Family Member

Enter whether or not the patient in Item 18a is an immediate family member.
eg: parent, sibling, child

If unknown, leave **BLANK**.

Item 16c. If yes, Same Anatomical Site

Enter whether or not the individual in Item 18b has the same type of cancer as the patient.

If unknown, leave **BLANK**.

Item 17. Alcohol Use

Indicate whether or not the patient has a history of alcohol use.
eg: current use, prior use, never used or unknown

Item 18. Tobacco Use

Indicate whether or not the patient has a history of tobacco use.
eg: current use, prior use, never used or unknown
for: cigarettes, pipe, snuff, chew

If the patient quit smoking one year or less from the initial date of diagnosis, indicate "current use."

Item 19. Medical Record Number

If the patient has been assigned a medical record number, enter that number.

If your hospital registry abstracts cases for another hospital, it should have a system that identifies the facility associated to the patient. This can be done by assigning a unique suffix or a prefix number to correspond with each facility and by communicating the system to the state registry staff.

If no medical record number exists for the patient, enter "none."

Item 20. Laboratory Record Number

If a case has been assigned a laboratory record number, enter that number.

If more than one laboratory record number has been assigned to the case, enter the number which most closely corresponds with the initial diagnosis of the primary tumor being reported.

If no laboratory number exists, enter "none."

If not reporting, leave the item blank.

Item 21. Accession and Sequence Number

The accession number is ONLY for 'hospitals with a registry,' in which case, the number would be assigned as the patient is enrolled into the system.

The accession and sequence number is a six-digit number.

The first two digits of the accession number specify the year in which the patient was first seen at the reporting institution for the diagnosis and/or treatment of cancer.

The last four digits of the accession number, is the numeric order in which the registrar entered the case into the registry.

Numeric gaps in accession numbers are allowed.

If a case is deleted from your database, do NOT reuse the accession number for another case.

The sequence number uniquely identifies the primary as either a single primary, secondary primary and so on, within the data set for a given registry.

If not reporting, leave this item blank.

Item 22. Type of Reporting Source

Code the source documents used to abstract the majority of information on the tumor being reported. This may not be the source of original casefinding.

Codes are as follows:
1 - Hospital inpatient; Managed health plans with comprehensive, unified medical records
2 - Radiation Treatment Centers or Medical Oncology Centers
(hospital-affiliated or independent)
3 - Laboratory only (hospital-affiliated or independent)
4 - Physician's office/private medical practitioner (LMD)
5 - Nursing/convalescent home/hospice
6 - Autopsy only
7 - Death certificate only
8 - Other hospital outpatient units/surgery cent

Item 23. Casefinding Source

Determine where the case was first identified and enter the appropriate code. In other words, what mechanism was used that identified the case for your review.
Each case may have a different casefinding source.

If a death certificate, independent pathology laboratory report, consultation-only report from a hospital, or other report was used to identify a case that was then abstracted from a different

source, enter the code for the source that first identified that case, not the source from which it was subsequently abstracted.

Codes are as follows:
10 - Reporting Hospital, NOS
20 - Pathology Department Review (surgical pathology reports, autopsies, or cytology reports)
21 - Daily Discharge Review (screen charts of discharged patients in medical records)
22 - Disease Index Review (review of disease index in the medical records department)
23 - Radiation Therapy Department/Center
24 - Laboratory Reports (other than pathology report code 20)
25 - Outpatient Chemotherapy
26 - Diagnostic Imaging/Radiology
(other than radiation therapy code 23; includes nuclear medicine)
27 - Tumor Board
28 - Hospital Rehabilitation Service or Clinic
29 - Other Hospital Source (including clinic, NOS or outpatient department, NOS)

Case first identified by source other than a reporting facility covered in the codes above:
30 - Physician-Initiated Case
40 - Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
50 - Independent (non-hospital) Pathology-Laboratory Report
60 - Nursing Home-Initiated Case
70 - Coroner‘s Office Records Review
75 - Managed Care Organization (MCO) or Insurance Records
80 - Death Certificate (case identified through death clearance)
85 - Out-of-State Case Sharing
90 - Other Non-Reporting Hospital Source
95 - Quality Control Review (case initially identified through quality control activities such as casefinding audit of a regional/central registry)
99 - Unknown

Item 24. Reporting Facility and City

Enter the name of the hospital, laboratory or registry where the report is being prepared.

Enter the city in which the hospital, laboratory or registry resides.

Item 25. Michigan Facility Number

Enter the facility number that has been assigned by the Michigan Cancer Surveillance Program.

If you do not know your facility number, contact your field representative.

Item 26. Class of Case

This field is ONLY required for ‘hospitals with a registry’.

If not reporting, leave item blank.

Codes are as follows:
00 - Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere

10 - Initial diagnosis AND part or all of first course treatment or a decision not to treat done at the reporting facility, NOS

11 - Initial diagnosis by staff physician AND part of first course treatment was done at the reporting facility

12 - Initial diagnosis by staff physician AND all first course treatment or a decision not to treat was done at the reporting facility

13 - Initial diagnosis AND part of first course treatment was done at the reporting facility

14 - Initial diagnosis AND all first course treatment or a decision not to treat was done at the reporting facility

20 - Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS

21 - Initial diagnosis elsewhere AND part of treatment was done at the reporting facility

22 - Initial diagnosis elsewhere AND all treatment was done at the reporting facility

30 - Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, staging workup after initial diagnosis elsewhere)

31 - Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care

32 - Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence

33 - Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only

34 - Type of case not required by CoC to be accessioned (for example, a benign colon tumor) having initial diagnosis AND part or all of first course treatment by reporting facility

35 - Case diagnosed before program‘s Reference Date, having initial diagnosis AND part or all of first course treatment by reporting facility

36 - Type of case not required by CoC to be accessioned (for example, a benign colon tumor) having initial diagnosis elsewhere AND all or part of first course treatment by reporting facility

37 - Case diagnosed before program‘s Reference Date, having initial diagnosis elsewhere AND all or part of first course treatment by facility

38 - Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death

40 - Diagnosis AND all first course treatment given at the same staff physician‘s office

41 - Diagnosis and all first course treatment given in two or more different staff physician offices

42 - Non-staff physician or non-CoC approved clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility

43 - Pathology or other lab specimens only

49 - Death certificate only

99 - Case not required by CoC to be abstracted of unknown relationship to facility (not for use by CoC approved cancer programs for analytic cases.)

Item 27a. Date of Inpatient Admission

Enter the year, month and day (**CCYY/MM/DD**) of the inpatient admission.

Date of the inpatient admission to the reporting facility for the most definitive surgery. In the absence of surgery, use date of inpatient admission for any other therapy. In the absence of therapy, use date of inpatient admission for diagnostic evaluation.

Item 27b. Date of Inpatient Admission Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:
10 - No information whatsoever can be inferred from this exceptional value (e.g., unknown if patient was an inpatient).

11 - No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility).

12 - A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown).

Blank - a valid date value is provided in item 27a

Item 28a. Date of Inpatient Discharge

Enter the year, month and day (**CCYY/MM/DD**) of the inpatient discharge.

Date of the inpatient discharge to the reporting facility for the most definitive surgery that corresponds to the admission date. In the absence of surgery, use date of discharge for any other therapy. In the absence of therapy, use date of discharge for diagnostic evaluation.

Item 28b. Date of Inpatient Discharge Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:
10 - No information whatsoever can be inferred from this exceptional value (e.g., unknown if patient was an inpatient).

11 - No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility).

12 - A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown).

Blank - a valid date value is provided in item Date of Inpatient Discharge

Item 29. Date of First Contact

Enter the year, month and day (**CCYY/MM/DD**) for the first date of contact.

Date of first patient contact, as inpatient or outpatient, with the reporting facility for the diagnosis and/or treatment of the tumor.

Item 30. Date of Diagnosis

Enter the year, month and day (**CCYY/MM/DD**) for the date of diagnosis.

Date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed.

If the diagnosis was determined by pathological examination, use the date the specimen was taken (date of biopsy or surgery), NOT the date the specimen was read by the pathologist or the date the report was dictated, transcribed or printed.

If the physician states that in retrospect the patient had cancer at an earlier date, then use the earlier date as the date of diagnosis.

Though the original diagnosis may be a clinical diagnosis that is later confirmed through pathological examination or other procedures, the clinical diagnosis date should be reported.

*Example* A patient underwent a mammogram on August 25, 1999. The radiologist read the report as suspicious for cancer, recommending biopsy. The patient does not get a biopsy until February 4, 2000 which reveals an infiltrating ductal adenocarcinoma.
*Record the date of diagnosis as August 25, 1999.*

If the month is unknown, use the month of **July (7)** for the month of diagnosis.

If the day is unknown, use the **fifteenth (15)** for the day of diagnosis.

If the year is unknown, estimate the diagnosis year based upon documentation in the medical record and how long the patient has had the diagnosis.

If an approximation is not possible, use the date first confirmed, first treated, or in the case of death, the date of death, whichever is earliest.

If a patient is diagnosed elsewhere before entering the reporting facility and the date of diagnosis is unknown, record the date the patient was first seen at the reporting hospital.

Use the date therapy was started as the date of diagnosis if the patient receives cancer directed treatment before a definitive diagnosis.

The date of death is the date of diagnosis for cases diagnosed at autopsy.

If information is limited to a description, use the following:

| | | | |
|---|---|---|---|
| "Spring" | April | "Middle of the year" | July |
| "Fall of the year" | October | "Winter of" | January or December |

Item 31. Primary Anatomical Site

Enter the primary anatomical site where the cancer began or originated. Include description of tumor origin or primary site.

The primary site can be located on the pathology report, attestation statement, history and physical examination, discharge summary, operative report, x-rays and scans.

Be as specific as possible, as many organs can be sub-divided into specific segments.

*Example* The pathology report indicates the tumor originated in the ascending colon. The primary site should be recorded as "C18.2, ascending colon" and NOT "C18.9, colon, NOS."

For leukemia and multiple myeloma, enter the primary site as bone marrow (C42.1).

Do NOT report the metastatic site(s) as the primary site.

If multiple primary tumors are diagnosed, complete a separate cancer report form for each primary site.

If the primary site cannot be determined, enter "*C80.9 unknown primary site*."

**NOTE: For further information, refer to the Primary Anatomical Site section.**

Item 32. Laterality (Paired Organ)

Laterality refers to a specific side of the body or lobe of an organ. In the case of paired or bilateral organs, it is important to indicate whether the primary site of the tumor is the right organ, the left organ, or bilateral involvement.

Laterality refers to the primary site only; **DO NOT** code the laterality of the metastatic site(s).

If the primary site is reported as "unknown primary site," code the laterality to "0-not a paired site."

Codes are as follows:
0 - Not a paired site
1 - Right: origin of primary
2 - Left: origin of primary
3 - Only one side involved, right or left origin unspecified
4 - Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5 - Paired site: midline tumor
9 - Paired site, but no information concerning laterality

**NOTE: For further information refer to the Paired Organ section.**

Item 33a. Clinical/Histological Diagnosis

**You MUST download and print the Multiple Primary and Histology Coding Rules manual from http://seer.cancer.gov/tools/mphrules/**

**You MUST also obtain a copy of the *International Classification of Diseases for Oncology, Third Edition (ICD-O-3)* coding book.**

**You MUST download the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic and Lymphoid Neoplasms Database from http://seer.cancer.gov/tools/heme/**

Record the clinical/histological diagnosis for the primary site being reported.

For hematopoietic and lymphoid neoplasms: code the histology diagnosed by the definitive diagnostic method(s) (see Hematopoietic database). The definitive diagnostic method can be a clinical diagnosis, genetic test, immunophenotyping, cytology, or pathology. When a pathology report is the definitive diagnostic method, code the histology from the final diagnosis, comment on the final diagnosis, addenda to the final diagnosis, or CAP protocol.

The Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic and Lymphoid Neoplasms Database, applies to only those **cases diagnosed January 1, 2010 and forward.**

Be as specific as possible when describing the histology of the primary site, as multiple terms may describe a single histology. Record ***all*** histological types and descriptive adjectives identified.

*Example* The pathology report diagnosis is that of a 'diffuse, large cell, non-cleaved lymphoma.' *Record the histology as 'diffuse, large cell, non-cleaved lymphoma (9680/3) not just 'lymphoma.'*

Review ***all*** pathology reports as specimens from the surgery are usually the most explicit.

*Example* The histology from a colon biopsy is reported as 'adenocarcinoma, NOS 8140/3).' The histology from the right hemicolectomy is reported as 'mucinous carcinoma (8480/3).' R*ecord the histology as 'mucinous carcinoma (8480/3).'*

EXCEPTION: There may be times when the biopsy removes all the tumor and the margins are negative. A wide excision will be performed for precautionary measures.

*Example* The pathology report from a skin biopsy identifies 'superficial malignant melanoma (8720/3).' At wide excision, no residual tumor is identified.
*Record the histology as 'superficial malignant melanoma (8720/3)' from the biopsy.*

Record the histology from the **most representative** tumor specimen examined and from the **final diagnosis.** The pathology reports takes precedence over all other reports.

***Note 1:*** Use information from **addenda** and **comments** associated with the final diagnosis to code the histology.

***Note 2:*** A **revised/amended diagnosis** replaces the original final diagnosis. Code the histology from the revised/amended diagnosis.

***Note 3:*** The new rules **limit** the information **to the final diagnosis**. The old rules allowed coding from information in the microscopic description. You will only use information from the microscopic portion of the pathology report when instructed to do so in one of the site-specific rules.

If there is NOT a pathology report and a **cytology report** is available, use the cytology report to determine the histology.

When you do not have either a pathology report or cytology report:

a. use documentation in the medical record that references pathology or cytology findings

b. assign the histology from mention of a type of cancer (histology) in the medical record

The words 'carcinoma' and 'adenocarcinoma' and 'cancer' are NOT interchangeable.
Record the histology exactly as it is reported.
If the histology is reported as 'carcinoma,' record the histology as 'carcinoma (8010/3).'

If the histology is reported as 'adenocarcinoma,' record the histology as 'adenocarcinoma, NOS (8140/3).'

If the diagnosis is 'cancer' and there is no mention of a specific histology type (carcinoma or adenocarcinoma), record the histology as 'cancer, NOS (8000/3).'

If no microscopic diagnosis is available, record the clinical diagnosis that describes the primary tumor being reported.

*Example* MRI of the brain demonstrates a mass in the frontal lobe. The radiologist indicates that the diagnosis is an anaplastic astrocytoma.
*Record the clinical diagnosis of 'anaplastic astrocytoma (9401/3)' made from MRI.*

If no histological diagnosis can be reached, or if no microscopic exam is available but a reportable diagnosis is suspected by a physician, report the suspected diagnosis.

*Example* Chest x-ray and CT scan reveals a mass in the right upper lobe. Right upper lobe bronchoscopy is performed and the diagnosis is negative for malignancy. Discharge diagnosis is reported as 'right lung cancer.' R*ecord the histology as 'cancer,' which is the suspected diagnosis by the managing physician.*

Item 33b. Behavior Code

Code for the behavior of the tumor being reported (see table below).

The following diagnoses have changed from a behavior 1 (borderline) to 3 (malignant):
Juvenile astrocytoma: code as 9421/**3**

Langerhans cell histiocytosis, NOS: code as 9571/**3**

T-cell large granular lymphocytic leukemia/Chronic lymphoproliferative disorder of NK cells: code as 9831/**3**

Myeloproliferative neoplasm, unclassifiable/Myelodysplastic/Myeloproliferative neoplasm, unclassifiable: code as 9975/**3**

| ***Code*** | ***Label*** | ***Definition*** |
|---|---|---|
| 0 | Benign | Benign |
| 1 | Borderline | Uncertain whether benign or malignant |
| | | Borderline malignancy |
| | | Low malignant potential |
| | | Uncertain malignant potential |
| 2 | In situ and/or carcinoma in situ | Adenocarcinoma in an adenomatous polyp with no invasion of stalk |
| | | Clark level 1 for melanoma (limited to epithelium) |
| | | Comedocarcinoma, non-infiltrating (C50.__) |
| 2 | Synonymous with in situ | Confined to epithelieum |
| | | Hutchinson melanotic freckle, NOS (C44.__) |

| *Code* | *Label* | *Definition* |
|---|---|---|
| 2 | Synonymous with in situ | Intracystic, non-infiltrating |
| | | Intraductal |
| | | Intraepidermal, NOS |
| | | Intraepithelial, NOS |
| | | Involvement up to, but not including the basement membrane |
| | | Lentigo maligna (C44.__) |
| | | Lobular neoplasia (C50.__) |
| | | Lobular, non-infiltrating (C50.__) |
| | | Non-infiltrating |
| | | No stromal involvement |
| | | Papillary, non-infiltrating or intraductal |
| | | Precancerous melanosis (C44.__) |
| | | Queyrat erythroplasia (C60.__) |
| 3 | Invasive | Invasive or micro-invasive |

Item 34. Grade/Differentiation

The instructions for coding grade and differentiation tumors are found in the "Morphology" section of the ICD-O-3 "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 30–34).

***FOR INSTRUCTIONS AND SITE-SPECIFIC GRADING SYSTEMS, YOU MUST GO TO THE TUMOR GRADE SECTION.***

The tumor grade applies to the primary site ONLY.

The grade of a tumor represents the pathological description of the degree to which the tumor tissue resembles normal tissue for that primary site. This is expressed in degrees of differentiation.

***Solid Tumors Only***

| *Description* | *Grade/Cell* | *Code* |
|---|---|---|
| Well differentiated; differentiated, NOS | Grade I; grade i; grade 1; | 1 |
| Moderately differentiated; moderately well differentiated; intermediate differentiation | Grade II; grade ii; grade 2; grade I/III; grade 1/3 | 2 |
| Poorly differentiated; dedifferentiated | Grade III; grade iii; grade 3; grade II/III; grade 2/3 | 3 |
| Undifferentiated; anaplastic | Grade IV; grade iv; grade 4; grade III/III; grade 3/3 | 4 |

***Lymphomas and Leukemias Only***

***You MUST download the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual from http://seer.cancer.gov/tools/heme/ which applies to only those cases diagnosed January 1, 2010 and forward, to assist with coding the tumor grade for these primaries.***

| *Description* | *Code* |
|---|---|
| T-cell; T-precursor; T-cell phenotype; Gamma-delta T | 5 |
| B-cell; Pre-B; B-precursor; B-cell phenotype | 6 |
| Null cell; Non-T cell; Non B-cell; Common Cell | 7 |
| NK - Natural Killer Cell | 8 |
| ***Solid Tumors and Hematopoietic and Lymphoid Neoplasms*** | |
| *Description* | *Code* |
| Combined T and B cell; Combined B and NK cell<br>Cell type not determined; Not stated; Not applicable; Unknown Primary | 9 |

Item 35. Grade Path System

Indicates whether a two, three or four grade system was used in the pathology report. Refer to the current *CS Manual* for coding instructions.

Codes are as follows:
2 - Two-Grade System
3 - Three-Grade System
4 - Four-Grade System
Blank: no grade system; unknown

Item 36. Grade Path Value

Describes the grade assigned according to the grading system in *Grade Path System*

Refer to the current *CS Manual* for coding instructions.

Codes are as follows:
1 - Recorded as Grade I or 1
2 - Recorded as Grade II or 2
3 - Recorded as Grade III or 3
4 - Recorded as Grade IV or IV
Blank: no grade system; unknown

Item 37. Lymph Vascular Invasion (LVI)

Indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist.

Codes are as follows:
0 - LVI not present; not identified
1 - LVI present
8 - Not applicable
9 - Unknown/indeterminate

Item 38. Diagnostic Confirmation

**THERE IS A SEPARATE CODING SCHEME FOR METHOD OF DIAGNOIS FOR HEMATOPOIETIC AND LYMPHOID NEOPLASMS. SEE PAGE 58.**

**Instructions for solid tumors:**

Diagnostic confirmation specifies whether a malignancy was confirmed microscopically AT ANY TIME during the disease course. This is a priority coding scheme with ***code 1*** taking precedence. A low number takes priority over all higher numbers.

| ***Method of Diagnosis - Codes for Solid Tumors*** | | |
|---|---|---|
| ***Microscopically Confirmed*** | | |
| ***Code*** | ***Definition*** | ***Explanation*** |
| 1 | Positive histology | Tissue specimens from biopsy, frozen section, surgery, autopsy, or dilation and curettage (D&C). Tissue is microscopically examined.<br><br>Bone marrow biopsy and bone marrow aspiration.<br><br>Hematologic confirmation of leukemia (i.e. peripheral blood smear) |

| *Method of Diagnosis - Codes for Solid Tumors* | | |
|---|---|---|
| ***Microscopically Confirmed*** | | |
| ***Code*** | ***Definition*** | ***Explanation*** |
| 2 | Positive cytology | Microscopic examination of cells removed from a neoplasm. Fine needle aspiration (FNA) is frequently used to obtain a cytologic specimen. Cells may be recovered from exudate, secretions, or washings from tissue.<br><br>No tissue microscopically examined; fluid cells microscopically examined.<br><br>*Examples:*<br>breast secretion<br>bronchial brushing<br>bronchial washings<br>cervical smear (pap smear)<br>gastric fluid<br>paraffin block from spinal, pleural or peritoneal fluid<br>prostatic secretions<br>spinal fluid<br>sputum smears<br>tracheal washings<br>urinary sediment<br>vaginal smears |
| 4 | Positive microscopic confirmation, method not specified | Microscopic confirmation is all that is known. It is unknown if the cells were examined by histology or cytology. |
| 5 | Positive laboratory test/marker study | A diagnosis of cancer is based on certain laboratory tests or marker studies that are CLINICALLY DIAGNOSTIC. This includes the presence of alpha-fetoprotein for liver cancer and an abnormal electrophoretic spike for multiple myeloma and Waldenstrom's macroglobulinemia.<br><br>An elevated PSA is non-diagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, record the code as 5. |
| 6 | Direct visualization without microscopic confirmation | Diagnosis which is confirmed by surgical exploration or endoscopy that is ***not*** supplemented by positive histology or cytology.<br>i.e. colposcope, mediastinoscope, peritoneoscope.<br><br>An autopsy only case (information obtained is from the gross autopsy report), diagnosis not confirmed by microscopic tissue analysis.) |

| *Method of Diagnosis - Codes for Solid Tumors* | | |
|---|---|---|
| ***Microscopically Confirmed*** | | |
| ***Code*** | ***Definition*** | ***Explanation*** |
| 7 | Radiography and other imaging techniques without microscopic confirmation | The malignancy was reported by the physician from an imaging technique report only.<br><br>Example: ultrasound, computerized (axial) tomography (CT or CAT scans) and magnetic resonance imaging (MRI). |
| 8 | Clinical diagnosis only (other than 5,6,7) | Cases diagnosed by clinical methods not mentioned previously.<br>i.e. mass in breast suspect a malignancy; no biopsies were taken.<br><br>Refer to the list of "Ambiguous Terminology" for language that represents a diagnosis of cancer. |
| 9 | Unknown whether or not microscopically confirmed | A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed.<br><br>Death certificate only cases. |

**Instruction for Coding Hematopoietic or Lymphoid Tumors (histology codes 9590-9992).**

There is no priority hierarchy for coding *Diagnostic Confirmation* for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing. See the *Hematopoietic Database (DB)* for information on the definitive diagnostic confirmation for specific types of tumors. ***You MUST download the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual from http://seer.cancer.gov/tools/heme/ which applies to only those cases diagnosed January 1, 2010 and forward, to assist with coding the method of diagnosis for these primaries.***

| *Method of Diagnosis - Codes for Hematopoietic and Lymphoid Neoplasms* | | |
|---|---|---|
| ***Code*** | ***Definition*** | ***Explanation*** |
| 1 | Positive histology | Tissue specimens from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy.<br><br>For leukemia only, code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear.<br><br>Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood. |

| *Method of Diagnosis - Codes for Hematopoietic and Lymphoid Neoplasms* | | |
|---|---|---|
| ***Code*** | ***Definition*** | ***Explanation*** |
| 2 | Positive cytology | Use code 2 when the microscopic diagnosis is based on cytologic examination of *cells* (rather than tissue).<br><br>No tissue microscopically examined; fluid cells microscopically examined.<br><br>Including but not limited to:<br>spinal fluid<br>peritoneal fluid<br>pleural fluid<br>urinary sediment,<br>cervical smears<br>vaginal smears<br>paraffin block specimens from concentrated spinal/pleural/peritoneal fluid<br><br>These methods are rarely used for hematopoietic or lymphoid tumors. |
| 3 | Positive histology PLUS Positive immunophenotyping AND/OR positive genetic studies | Use when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results.<br><br>Do not use this code for neoplasms diagnosed prior to January 1, 2010. |
| 4 | Positive microscopic confirmation, method not specified. | Microscopic confirmation is all that is known. It is unknown if the cells were examined by histology or cytology. |
| 5 | Positive laboratory test/marker study | Use when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but no positive histologic confirmation. |
| 6 | Direct visualization without microscopic confirmation | Use code 6 when the diagnosis is based only on the surgeon's report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings. |
| 7 | Radiography and other imaging techniques w/out microscopic confirmation | The malignancy was reported by the physician from an imaging technique report only. |

| *Method of Diagnosis - Codes for Hematopoietic and Lymphoid Neoplasms* | | |
|---|---|---|
| ***Code*** | ***Definition*** | ***Explanation*** |
| 8 | Clinical diagnosis only (other than 5,6,7) | Use code 8 when the case was diagnosed by any clinical method that can not be coded as 5, 6 or 7.<br><br>A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation. |
| 9 | Unknown whether or not microscopically confirmed | A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed.<br><br>Death certificate only cases. |

Item 39. SEER Summary Stage

***Use SEER Summary Staging Manual - 2000, Codes and Coding Instructions for cases diagnosed on or after January 1, 2001.***

Download and print the manual from http://seer.cancer.gov/tools/ssm/

The summary stage should include all information available through completion of surgery(ies) in the ***first course of treatment or within four months from the date of initial diagnosis***.

The codes are as follows:

0 - In situ, Intraepithelial, Noninvasive, Noninfiltrating
1 - Localized ONLY (within organ)
2 - Regional by direct extension ONLY
3 - Regional to lymph node(s) ONLY
4 - Regional by BOTH direct extension AND regional lymph node(s) involved
5 - Regional, NOS (not otherwise specified)
7 - Distant site(s)/lymph node(s) involved or Systemic
8 - BENIGN
9 - Unknown if extension or metastasis; Unknown primary site; Death certificate only case
Class of case 3 or 4 when stage at initial diagnosis is unknown

**NOTE: For further instructions refer to the SEER Summary Staging section.**

Item 40. AJCC Stage

The need to report AJCC stage information is restricted to facilities operating cancer registries and with staff trained to determine AJCC stage. The American Joint Committee on Cancer (AJCC) stage is ONLY required for hospitals with a registry.

T – definition of the primary tumor
N – involvement of regional lymph nodes
M – metastatic involvement beyond the primary site

Stage Group – sum of the TNM; groups are classified by Roman numerals from I to IV with increasing severity of disease.

Refer to the appropriate AJCC Cancer Staging Manual, based upon the date of initial diagnosis to determine the stage.

Cases diagnosed January 1, 2010 or after – Seventh Edition.
Cases diagnosed between January 1, 2003 and December 31, 2009 - Sixth Edition.

If you are unable to use the appropriate edition of the AJCC Cancer Staging Manual based upon the date of initial diagnosis, use the most current edition to stage the case. It is then very critical that you indicate which edition was used to determine the stage.

Clinical classification is based upon information and evidence obtained before treatment.

Pathological classification is based upon information obtained before treatment AND is supplemented by additional evidence from surgery and the pathologic examination of the resected specimen.

If not reporting, leave this item blank.

Item 41. CS Tumor Size (mm)

Records the largest dimension or diameter of the primary tumor in millimeters.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 42. CS Extension

Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs.
**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 43. CS Tumor Size/Ext Evaluation

Records how the codes for the two items CS tumor size and CS extension were determined, based on the diagnostic methods employed.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 44. CS Lymph Nodes

Identifies the regional lymph nodes involved with cancer at the time of diagnosis.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 45. CS Regional Nodes Evaluation

Records how the code for *CS Lymph Nodes* (NAACCR Item #2830) was determined, based on the diagnostic methods employed.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 46. Regional Lymph Nodes Examined

1. Record information about only regional lymph nodes in this field. Distant lymph node information should be coded in the "CS Mets at Dx" field.

2. Rules for coding Regional Nodes Examined are the same for in situ and invasive cases.

3. This field is based on pathologic information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed but no lymph nodes were found, code as 00. If it is unknown whether nodes were removed or examined, code as 99.

4. Record the total number of regional lymph nodes removed and examined by the pathologist.

a. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

b. If lymph nodes are aspirated and other lymph nodes are removed, use code 98.

c. This field is to be recorded regardless of whether the patient received preoperative treatment.

5. If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, use code 96.

Codes are as follows:
Code 00 - No nodes were examined.

Codes 01 – 89 - 1-89 nodes were examined. (Code the exact number of regional lymph nodes examined.)

Code 90 - 90 or more nodes were examined.

Code 95 - No regional nodes were removed, but aspiration or core biopsy of regional nodes was performed.

Code 96 - Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated.

Code 97 - Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated.

Code 98 - Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown.

Code 99 - It is unknown whether nodes were examined; not applicable or negative; not stated in patient record.

For the following primary sites and histologies, the Regional Nodes Positive field is always coded as 99.

Placenta
Brain and Cerebral Meninges
Other Parts of Central Nervous System
Hodgkin and non-Hodgkin Lymphoma
Hematopoietic, Reticuloendothelial and Immunoproliferative Neoplasms
Myeloproliferative Neoplasms
Other and Ill-Defined Primary Sites
Unknown Primary Site

Item 47. <u>Regional Lymph Nodes Positive</u>

1. Record information about only regional lymph nodes in this field. Involved distant lymph nodes should be coded in the “CS Mets at Dx” field.

2. Rules for coding Regional Nodes Positive are the same for both in situ and invasive cases.

3. This field is based on pathologic information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed but no lymph nodes were found, code as 98.

4. Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.

a. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
b. This field is to be recorded regardless of whether the patient received preoperative treatment.

5. Any combination of positive aspirated, biopsied, sampled or dissected lymph nodes should be coded to 97 if the number of involved nodes cannot be determined on the basis of cytology or histology.

Codes are as follows:
Code 00 - All nodes examined are negative.

Codes 01 to 89 – 1 to 89 nodes are positive. (Code exact number of nodes positive)

Code 90 - 90 or more nodes are positive.

Code 95 - Positive aspiration or core biopsy of lymph node(s) was performed.

Code 97 - Positive nodes are documented, but the number is unspecified.

Code 98 - No nodes were examined.

Code 99 - It is unknown whether nodes are positive; not applicable; not stated in patient record.

For the following primary sites and histologies, the Regional Nodes Positive field is always coded as 99.

Placenta
Brain and Cerebral Meninges
Other Parts of Central Nervous System
Hodgkin and non-Hodgkin Lymphoma
Hematopoietic, Reticuloendothelial and Immunoproliferative Neoplasms
Myeloproliferative Neoplasms
Other and Ill-Defined Primary Sites
Unknown Primary Site

Item 48. <u>CS Mets at Diagnosis</u>

This data item represents distant metastases (the TNM M component or distant stage in Summary Staging) at the time of diagnosis. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to a site remote from the primary tumor.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03) Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 49. CS Mets at Dx – Bone

Identifies the presence of distant metastatic involvement of bone at time of diagnosis.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03) Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 50. CS Mets at Dx – Brain

Identifies the presence of distant metastatic involvement of brain at time of diagnosis.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03) Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 51. CS Mets at Dx – Liver

Identifies the presence of distant metastatic involvement of liver at time of diagnosis.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03) Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 52. CS Mets at Dx – Lung

Identifies the presence of distant metastatic involvement of lung at time of diagnosis.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03) Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 53. CS Mets Evaluation

Records how the code for *CS Mets at Dx* (NAACCR Item #2850) was determined based on the diagnostic methods employed.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 54. CS Site-Specific Factor 1

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 55. CS Site-Specific Factor 2

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 56. CS Site-Specific Factor 3

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 57. CS Site-Specific Factor 4

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 58. CS Site-Specific Factor 5

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 59. CS Site-Specific Factor 6

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 60. CS Site-Specific Factor 7

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 61. CS Site-Specific Factor 8

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 62. CS Site-Specific Factor 9

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 63. CS Site-Specific Factor 10

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 64. CS Site-Specific Factor 11

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 65. CS Site-Specific Factor 12

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 66. CS Site-Specific Factor 13

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 67. CS Site-Specific Factor 14

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 68. CS Site-Specific Factor 15

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 69. CS Site-Specific Factor 16

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 70. CS Site-Specific Factor 17

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 71. CS Site-Specific Factor 18

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 72. CS Site-Specific Factor 19

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 73. CS Site-Specific Factor 20

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 74. CS Site-Specific Factor 21

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 75. CS Site-Specific Factor 22

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 76. CS Site-Specific Factor 23

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 77. CS Site-Specific Factor 24

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 78. CS Site-Specific Factor 25

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Item 79. Rx Summ – Rx Status

Summary of the status for ALL treatment modalities (ie: surgery, chemotherapy, radiation therapy, BRM, immunotherapy, etc)

Codes are as follows:
0 – No treatment given
1 – Treatment given
2 – Active Surveillance (watchful waiting)
9 – Unknown if treatment given

**If NO treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered SKIP to ITEM # 97a.**

Item 80a. Date of First Course of Treatment

Enter the year, month and day (**CCYY/MM/DD**) for the date of first course of treatment. Consider all therapies that have been administered. This includes any surgery, radiation therapy, chemotherapy, hormone therapy or immunotherapy (biological response modifier therapy) that has been described as a recommended part of the treatment plan.

Record the FIRST date that the patient received treatment.

Item 80b. Date First Course of Treatment Flag

This flag explains why there is no appropriate value in the corresponding date field, Date of First Course of Treatment.

Codes are as follows:
10 - Unknown if surgery performed
11 - No surgery performed
12 - Surgery performed, but date unknown
BLANK - Valid date provided in item 78a

Item 81. Systemic/Surgery Sequence

Record the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

Codes are as follows:
0 - No systemic therapy and/or surgical procedure(s)
2 - Systemic therapy before surgery
3 - Systemic therapy after surgery
4 - Systemic therapy both before AND after surgery
5 - Intra-operative systemic therapy
6 - Intra-operative systemic therapy w/other systemic therapy administered before OR after surgery
9 - Sequence unknown

Item 82. Reason for No Surgery of Primary Site

Enter the reason no cancer directed surgery was performed for the primary site. Use the number that best describes why the primary site surgery was not performed.

Codes are as follows:
0 - Surgery of primary site was performed
1 - Surgery of primary site was not performed because it was not part of the planned first course of treatment
2 - Surgery of primary site was not recommended because it was contraindicated due to patient risk factors
5 - Surgery of primary site was not performed because the patient died prior to planned or recommended surgery
6 - Surgery of primary site was not performed but recommended; reason unknown
7 - Surgery of primary site was not performed; recommended by patient's physician but refused

8 - Surgery of primary site was recommended, but unknown if it was performed.
9 - It is unknown whether surgery of the primary site was recommended or performed; diagnosed at autopsy

Item 83a. Date of First Surgical Procedure

Enter the year, month and day (**CCYY/MM/DD**) for the date of first course of treatment.

Record the earliest date on which any first course surgical procedure was performed.

If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item Date of First Course of Treatment.

Item 83b. Date of First Surgical Procedure Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:
10 - Unknown if surgery performed
11 - No surgery performed
12 - Surgery performed, but date unknown
BLANK - Valid date provided in item 81a

Item 84. Surgical Procedure of Primary Site

Record the surgical procedure(s) performed to the primary site.

Site-specific codes for this data item can be found in Appendix B of the 2010 *Facility Oncology Registry Data Standards (FORDS) Manual*. Vist the following website for the FORDS manual: *http://www.facs.org/cancer/coc/fords/FORDS_for_2010c_03012010.pdf*

In addition to the procedure code, record the description as documentated on the operative report.

Excisional biopsies (those that remove the entrie tumor and/or leave only microscopic margins) are to be coded in this item.

Item 85. Surgical Procedure/Other Site

Record the surgical removal of distant lymph nodes or other tissue (s)/organ(s) beyond the primary site.

Codes are as follows:
0 - None
1 - Nonprimary surgical procedure performed
2 - Nonprimary surgical procedure to other regional sites
3 - Nonprimary surgical procedure to *distant lymph node(s)*
4 - Nonprimary surgical procedure to distant site
5 - Combinaton of codes
9 - Unknown

Item 86. Scope of Regional Lymph Node Surgery

Record the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

The scope of regional lymph node surgery is collected for each surgical event even if the surgery of the primary sited was not performed.

Codes are as follows:
0 - None
1 - Biopsy or aspiration of regional lymph node, NOS
2 - Sentinel lymph node bx
3 - Number of regional lymph node removed unknown or not stated; regional lymph node, NOS
4 - 1 to 3 regional lymph nodes removed
5 - 4 or more regional lymph nodes removed
6 - Sentinel node biopsy and code 3, 4 or 5 at same time, or timing not stated
7 - Sentinel node biopsy and code 3, 4, or 5 at different times
9 - Uknown or not applicable

Item 87. Radiation//Surgery Sequence

Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Codes are as follows:
0 - No radiation therapy and/or surgical procedure(s)
2 - Radiation therapy before surgery
3 - Radiation therapy after surgery
4 - Radiation therapy both before AND after surgery
5 - Intraoperative radiation therapy
6 - Intraoperative radiation therapy w/other therapy administered before OR after surgery
9 - Sequence unknown

Item 88a. Date Radiation Started

Enter the year, month and day (**CCYY/MM/DD**) for the date radiation was started.

Record the date on which radiation therapy began at any facility that is part of the first course of treatment.

Item 88b. Date Radiation Started Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:
10 - Unknown if surgery performed
11 - No surgery performed
12 - Surgery performed, but date unknown
BLANK - Valid date provided in item 81a

Item 89. Reason No Radiation

Records the reason that no regional radiation therapy was administered to the patient.

0 - Radiation therapy was administered.
1 - Radiation therapy was not administered because it was not part of the planned first course treatment.
2 - Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation etc.).
5 - Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6 - Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7 - Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in record.
8 - Radiation therapy was recommended, but it is unknown whether it was administered.
9 - It is unknown if radiation therapy was recommended or administered. Death certificate and autopsy cases only

Item 90. Radiation Treatment Modality

Record the dominant modality of radiation therapy used to deliver the most clinically significant dose to the primary volume of interest during the first course of treatment.

Include a description and sites radiated along with start dates.

Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment.

Codes are as follows:
00 - No radiation treatment - Radiation therapy was not administered to the patient; diagnosed at autopsy.

20 - External beam, NOS - The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.

21 - Orthovoltage - External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).

22 - Cobalt-60, Cesium-137 - External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.

23 - Photons (2–5 MV) - External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV.

24 - Photons (6–10 MV) - External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV.

25 - Photons (11–19 MV) - External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV.

26 - Photons (>19 MV) - External beam therapy using a photon producing machine with a beam energy of more than 19 MV.

27 - Photons (mixed energies) - External beam therapy using more than one energy over the course of treatment.

28 - Electrons - Treatment delivered by electron beam.

29 - Photons and electrons mixed - Treatment delivered using a combination of photon and electron beams.

30 - Neutrons, with or without photons/electrons - Treatment delivered using neutron beam.

31 - IMRT - Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.

32 - Conformal or 3-D therapy - An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.

40 - Protons - Treatment delivered using proton therapy.

41 - Stereotactic radiosurgery, NOS - Treatment delivered using stereotactic radiosurgery, type not specified in patient record.

42 - Linac radiosurgery Treatment categorized as using stereotactic technique delivered with a linear accelerator.

43 - Gamma Knife Treatment - categorized as using stereotactic technique delivered using a Gamma Knife machine.

50 - Brachytherapy, NOS - Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, or intracavitary applicators of radioactive materials not otherwise specified.

51 - Brachytherapy, Intracavitary, LDR - Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).

52 - Brachytherapy, Intracavitary, HDR - Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.

53 - Brachytherapy, Interstitial, LDR - Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.

54 - Brachytherapy, Interstitial, HDR - Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.

55 - Radium - Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.

60 - Radioisotopes, NOS Iodine-131, Phosphorus-32, etc.

61 - Strontium-89 - Treatment primarily by intravenous routes for bone metastases.

62 - Strontium-90

98 - Other, NOS - Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown.

99 - Unknown - It is unknown whether radiation therapy was administered.

Item 91a. Date Chemotherapy Started

Enter the year, month and day (**CCYY/MM/DD**) for the date chemotherapy was started.

Record the date on which chemotherapy was administered at any facility that is part of the first course of treatment.

Item 91b. Date Chemotherapy Flag

This flag explains why there is no appropriate value in the corresponding date field.
Codes are as follows:
10 - Unknown if chemo administered
11 - No chemo administered
12 - Chemo given, but date unknown
15 - Chemo planned, but not started
BLANK - Valid date provided in item 88a

Item 92. Chemotherapy

Record the type of chemotherapy administerd as first course treatment at this and all other facilities.

Record chemotherapeutic agents used in data item 101.

Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.

Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.

If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

Code 88 if it is known that a physician recommended the patient receive chemotherapy but no further documentation is available yet to confirm its administration

Code 88 to indicate referral was made medical oncologist and the registry must follow to determine whether it was given. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.

Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.

Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved.

If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and only the original agent or regimen is recorded as first course therapy.

Refer to the *SEER*Rx Interactive Drug Database at http://seer.cancer.gov/* for a list of chemotherapeutic agents.

Codes are as follows:
00 - None; no chemotherapy administered

01 - Chemotherapy administered as first course therapy; type/agents not documented

02 - Single-agent chemotherapy administered as first course therapy

03 - Multi-agent chemotherapy administered as first course therapy

82 - Chemo was not recommended/administered because it was contraindicated due to patient risk factors

85 - Chemotherapy was not administered because patient expired prior to planned therapy

86 - Chemotherapy recommended but not administered; reason unknown

87 - Chemotherapy recommended but refused by patient or family

88 - Chemotherapy recommended but unknown if administered

99 - Unknown whether chemotherapy was recommended or administered

Item 93. Hematologic Transplant and Endocrine Procedures

Identifies systemic therapeutic *procedures* administered as part of the first course of treatment at this and all other facilities. If none of these *procedures* were administered, then this item

records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.

Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.

Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or affect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.

Code 00 if a transplant or endocrine procedure was not administered to the patient, and it is known that these procedures are not usually administered for this type and stage of cancer.

Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure.

If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

Code 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

Code 88 if it is known that a physician recommended a hematologic transplant or endocrine procedure, but no further documentation is available yet to confirm its administration.

Code 88 to indicate referral to a specialist for hematologic transplant or endocrine procedures and the registry should follow the case. If follow-up to the specified specialist or facility determines the patient was never there, code 00.

Cases coded 88 should be followed to determine whether they were given a hematologic transplant or endocrine procedure or why not.

Code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

Codes are as follows:
00 - No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy.

10 - A bone marrow transplant procedure was administered, but the type was not specified.

11 - Bone marrow transplant–autologous.

12 - Bone marrow transplant–allogeneic.

20 - Stem cell harvest and infusion. Umbilical cord stem cell transplant.

30 - Endocrine surgery and/or endocrine radiation therapy.

40 - Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20.)

82 - Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of disease prior to administration, etc.).

85 - Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.

86 - Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.

87 - Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.

88 - Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.

99 - It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only.

Item 94a. Date Hormone Started

Enter the year, month and day (**CCYY/MM/DD**) for the date hormone was started.

Record the date on which hormone was administered at any facility that is part of the first course of treatment.

Item 94b. Date Hormone Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:
10 - Unknown if hormone administered
11 - No hormone administered
12 - Hormone administered, but date unknown
15 - Hormone planned, but not started

BLANK - Valid date provided in item 90a

Item 95. Hormone Therapy

Record the type of hormone therapy administered as first course treatment at this facility. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Record hormones administered in data item 104.

Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.

Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.

Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.

Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy.

Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.

If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.

Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of hormonal agents.

Codes are as follows:
00 - None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.

01 - Hormone therapy administered as first course therapy.

82 - Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of tumor prior to administration, etc.).

85 - Hormone therapy was not administered because the patient died prior to planned or recommended therapy.

86 - Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.

87 - Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.

88 - Hormone therapy was recommended, but it is unknown if it was administered.

99 - It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Item 96a. Date Immunotherapy Started

Enter the year, month and day (**CCYY/MM/DD**) for the date immunotherapy was started.

Record the date on which immunotherapy was administered at any facility that is part of the first course of treatment.

Item 96b. Date Immunotherapy Hormone Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:
10 - Unknown if immunotherapy administered
11 - No immunotherapy administered
12 - Immunotherapy given, date unknown
15 - Immunotherapy planned, but not started
BLANK - Valid date provided in item 93a

Item 97. Immunotherapy

Records the type of immunotherapy administered as first course treatment at this facility. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Record immunotherapy administered in data item 101.

Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.

Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include immunotherapy.

If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

Code 88 if it is known that a physician recommended the patient receive immunotherapy but no further documentation is available yet to confirm its administration.

Cases coded 88 should be followed to determine whether they received immunotherapy or why not.

Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

Refer to the *SEER*Rx Interactive Drug Database (http://seer.cancer.gov/)* for a list of immunotherapeutic agents.

Codes are as follows:
00 - None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.

01 - Immunotherapy administered as first course therapy.

82 - Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age).

85 - Immunotherapy was not administered because the patient died prior to planned or recommended therapy.

86 - Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.

87 - Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.

88 - Immunotherapy was recommended, but it is unknown if it was administered.

99 - It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Item 98a. Date Other Treatment Started

Enter the year, month and day (**CCYY/MM/DD**) for the date other treatment was started.

Record the date on which other treatment was administered at any facility that is part of the first course of treatment.

Item 98b. Date Other Treatment Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:
10 - Unknown if therapy administered
11 - No therapy administered
12 - Therapy administered, but date unknown
BLANK - Valid date provided in item 95a

Item 99. Other Treatment

Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

The principal treatment for certain reportable hematopoietic diseases could be supportive care that does not meet the usual definition of treatment that "modifies, controls, removes, or destroys" proliferating cancer tissue.

Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as "Other Treatment" (Code 1) for the hematopoietic diseases ONLY.

Code 1 for embolization using alcohol as an embolizing agent.

Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.

Do not code presurgical embolization that given for a purpose to shrink the tumor.

A complete description of the treatment plan should be recorded in the text field for "Other Treatment" on the abstract.

Codes are as follows:
0 – None - All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.

1 – Other - Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy).

2 – Other - Experimental This code is not defined. It may be used to record participation in institution based clinical trials.

3 – Other - Double Blind A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.

6 – Other - Unproven Cancer treatments administered by nonmedical personnel.

7 – Refusal - Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.

8 - Recommended; unknown if administered; Other treatment was recommended, but it is unknown whether it was administered.

9 – Unknown - It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

Item 100a. Date of Last Contact

Records the date of last contact with the patient or the date of death.

Record the last date on which the patient was known to be alive or the date of death.

Item 100b. Date of Last Contact Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:
12 - Date of last contact unknown
BLANK - Valid date provided in item 97a

**TEXT FIELDS:** Text may be needed to justify the codes selected for the data items and to allow recording information that is not coded at all. It is a component of a complete electronic abstract, and allows for the full abstract to be printed or reviewed on the screen as needed. In addition, the text is used for quality control and special studies. As the purpose of text information is to provide the opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values. When the supporting text information is printed for review, one should be able to re-abstract the case without obtaining additional medical records and have the same codes as the original abstract.

Record at a minimum the following information for the text data items:

The date of the examination or procedure

The name of the examination or procedure

The results of the examination or procedure - any pertinent positive or negative information

The diagnostic impression, if one is given.

Item 101. Text – Physical Exam/Signs and Symptoms/Lab Results (PSA, CEA)

Item 102. Text - X-rays/Scans (Interpretation of scan justifying staging)

Item 103. Text – Biopsy/Scopes/Staging/Pathology Report

Item 104. Text – Chemotherapy/Hormone Therapy/Immunotherapy/Other Therapy (List Agents Administered)

Item 105. Text – Radiation Therapy/Miscellanous

Item 106. Abstractor Name and Contact Number

Enter the name of the person who prepared the cancer report form.

Enter the phone number of the person who prepared the cancer report form.

Item 107. Vital Status

Record the vital status of the patient as of the last contact in the box provided.

If vital status is not known, answer unknown.

Item 108. Date of Death

If patient's vital status is "0" this item must be completed.

Enter the year, month, and day (**CCYY/MM/DD**) of the patient's death.

Item 109. Death Cause

Enter the cause of death as listed on the death certificate.

If cause of death is unknown, leave blank.

Item 110. Death State

Enter the state in which the patient expired.

If death state is unknown, leave blank.

Item 111. Date Abstracted

Enter the year, month, and day (**CCYY/MM/DD**) the cancer report form was completed.

## FOLLOW-UP WORK ON REPORTED CASES

Contact with the reporting entity concerning an individual cancer report or a specific patient will occur under four separate circumstances. As is consistent with administrative Rules; the cooperation of facility personnel in these four areas is essential. Should problems or concerns arise, please feel free to contact the office.

1. As cancer reports are received and processed, each will be reviewed for completeness, legibility and consistency. Contact with the reporting entity will occur to resolve identified problems in these areas as forms are initially processed and later as final processing occurs. Contacts will generally be by e-mail (if no patient identifiers) or phone. Prompt attention to such issues by the personnel responsible for completing these reports is important to smooth processing.

2. In assessing the quality of the cancer reports received from across the state, the office will contact hospitals, laboratories or registries for access to or copies of pertinent records. This activity is necessary to evaluate the quality and completeness of the information received from individual reporting entities and for the state cancer registry as a whole. Problems that are identified during such reviews will be addressed as necessary to maintain or improve data quality and usefulness.

3. Contact may also occur to conduct approved epidemiological research projects. When a research study is approved by the Director of the Michigan Department of Community Health, study subjects will be drawn from the state registry. Hospitals, laboratories and registries will be contacted concerning each case reported by them to ascertain the physician treating the patient. Through this process, physicians can then be contacted and patient consent obtained.

4. Death follow back study (also known as ‘unlinked deaths’) is part of the department's passive case finding system. The process of the death follow back study is basically as follows:

    a. the previous years death file is reviewed for all death certificates that indicate some involvement of cancer
    b. the cases that indicate involvement of cancer are then matched against the cancer registry
    c. those decedents that do not match the cancer registry and indicate involvement of cancer are then pulled
    d. these cases are reviewed to see if they appear to meet the reporting criteria
    e. if after the review they appear to be unreported cancer cases are queried
    f. unreported cases are either queried through the hospital where the patient died or through the certifying physician for follow up information
    g. after receiving the follow up information a decision is made: either the case meets reporting criteria and a cancer report is filed or the case does not meet reporting criteria and is not added to the cancer registry

The death certificate information is a valuable tool in case finding. The types of cases that we have found are those that have not been definitively diagnosed, or cases that are not diagnosed until death occurred. Through the death follow back study we add cases yearly which helps to create a more complete state cancer registry.

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## REPORTABLE CONDITIONS

The first step in any case finding effort is to outline what is reportable. The administrative rules on cancer reporting provide the definition of a reportable cancer. All cases satisfying this definition are reportable. The residence of the patient is not a factor.

> *"Cancer" means all diagnoses with a behavior code of "2" (carcinoma in situ) or "3" (malignant primary site) as listed in the most recently amended International Classification of Diseases for Oncology, excluding basal, epithelial, papillary and squamous cell carcinomas of the skin, but including carcinomas of the skin prepuce, clitoris, vulva, labia, penis and scrotum.*

Cases diagnosed on or after ***January 1, 1985 to date*** MUST be reported to the Michigan Cancer Surveillance Program ***within 180 days or six months from the date of initial diagnosis***.

Once a neoplasm has been identified, it is assigned a six digit morphology code (e.g. 8522/34) from the International Classification of Diseases for Oncology, Third Edition (ICD-O-3) coding book. The first four digits record the cell type or histology. The fifth digit, after the slash or solidus (/), is the behavior code and the sixth digit is the tumor grade. All neoplasms assigned a Fifth Digit Behavior Code of '2' or '3' in the ICD-O-3 are reportable.

Non-malignant primary intracranial and central nervous system tumors diagnosed on or after **October 1, 2004** or later with a behavior code of '0' or '1' will be collected for the following site codes based on *The International Classification of Disease Oncology, Third Edition (ICD-O-3)*: meninges (C70.0 – C70.9); brain (C71.0 – C71.9); spinal cord, cranial nerves, and other parts of the central nervous system (C72.0 – C72.9); pituitary gland (C75.1); craniopharyngeal duct (C75.2); and pineal gland (C75.3).

Juvenile astrocytomas listed as 9421/**1** in ICD-O-3 are required and should be recorded as 9421/**3**, thereby making it a reportable condition.

| ***ICD-O-3 Fifth Digit Behavior Codes for Neoplasms*** | | | |
|---|---|---|---|
| ***Behavior Code*** | ***Definition*** | ***Reportable*** | ***Non-Reportable*** |
| /0 | Benign<br>EXCEPTION: Brain and CNS | | **X** |
| /1 | Uncertain whether benign or malignant<br>Borderline malignancy<br>Low malignant potential<br>Uncertain malignant potential<br>EXCEPTION: Brain and CNS | | **X** |
| /2 | Carcinoma In Situ<br>Intraepithelial<br>Noninfiltrating<br>Noninvasive | **X** | |
| /3 | Malignant, primary site | **X** | |

| *ICD-O-3 Fifth Digit Behavior Codes for Neoplasms* | | | |
|---|---|---|---|
| ***Behavior Code*** | ***Definition*** | ***Reportable*** | ***Non-Reportable*** |
| /6* | Malignant, metastatic site<br>Malignant, secondary site | | **X** |
| /9* | Malignant, uncertain whether primary or metastatic site<br><br>* Not used by cancer registries. | | **X** |

*NOTE:* Screening of diagnostic codes for behavior codes "6 - malignant, metastatic site," and "9 - malignant, uncertain whether primary or metastatic site" is necessary for casefinding. If this is the first diagnosis of this cancer and even though it is the metastatic site, it is still a reportable condition. The first time a diagnosis of cancer is made with an "unknown primary" it should be reported as such. If the primary site is determined after further study and it was originally reported as an unknown primary, a correction MUST be reported. The behavior code of "6" is only allowed to be used by central registries. When reporting an unknown primary site, a behavior code "3 - malignant" must be used.

***Benign Brain and CNS***

For benign/borderline intracranial and central nervous system tumors, the terms 'tumor' and 'neoplasm' are considered diagnostic for the purpose of case reporting, in addition to the terms generally applicable to malignant tumors.

If the final pathologic diagnosis is 'CNS neoplasm' or 'mass,' there must be an ICD-O-3 code for the mass or neoplasm. If there is not an ICD-O-3 code, the case is NOT reportable.

Diagnoses like 'hypodense mass' or 'cystic neoplasm' are NOT reportable even for CNS sites.

If the ONLY diagnosis available is 'CNS tumor' or 'neoplasm' the case is reportable and the histology is coded as M-8000/1 (Neoplasm, NOS, uncertain whether benign or malignant.)

***Reportable Histologies***

Craniopharyngioma (M9350)
Rathke Pouch Tumor (M9350)
Chordomas (M9370)
Schwannoma (M9560)
Acoustic Schwannoma/Neuroma
Dermoid Cyst (M9084)
Granular Cell Tumor (M9580)
Embryonal Tumors
Retinoblastoma (M9510)
Primitive Neuroectodermal Tumors (PNET)
Lymphoma
Vascular Tumors (arise from blood vessels of brain and spinal cord)
Hemangioblastoma (M9161)

***Non-Reportable Histologies***
Rathke Cleft Cyst
Epidermoid Cyst
Colloid cyst
Enterogenous Cyst
Neuroglial Cyst
Plasma Cell Granuloma
Nasal Glial Heterotopia

The following conditions are considered reportable and MUST be reported to the Michigan Cancer Surveillance Program.

| ***Reportable Conditions*** | | | |
|---|---|---|---|
| ***ICD-9-CM Code*** | ***Primary Site*** | ***Histology Code*** | ***Topography Code*** |
| 230.5 | AIN III (anal intraepithelial neoplasia) | 8077/2 | C21.1 |
| 233.1 | CIN III (cervical intraepithelial neoplasia) with or without carcinoma in situ (CIS)<br><br>Severe dysplasia ALONE is reportable. | 8077/2 | C53.0 - C53.9 |
| 233.1 | HSIL (high-grade squamous intraepithelial lesion) with or without carcinoma in situ (CIS); with or without CIN III; with or without severe dysplasia.<br><br>(*NOTE:* A diagnosis of "HSIL, moderate dysplasia" is NOT reportable.) | 8077/2 | C53.0 - C53.9 |
| 191.0 - 191.9 | Juvenile astrocytoma<br>Pilocytic astrocytoma<br>Piloid astrocytoma | 9421/1<br>9421/3 | C71.1 - C71.9 |
| 233.3 | VAIN III (vaginal intraepithelial neoplasia) with or without carcinoma in situ (CIS)<br><br>(*NOTE:* A diagnosis of "VAIN III, severe dysplasia" is NOT reportable.) | 8077/2 | C52.0 - C52.9 |
| 233.3 | VIN III (vulvar intraepithelial neoplasia) with or without carcinoma in situ (CIS)<br><br>(*NOTE:* A diagnosis of "VIN III, severe dysplasia" is NOT reportable.) | 8077/2 | C51.0 - C51.9 |

***Exclusions to Reportable Conditions***

The Michigan Cancer Surveillance Program has exclusions to the collection of skin malignancies based upon the primary site and histology. If the following histologies arise in the skin (C44.0 - C44.9) they are NOT reportable regardless of the stage at the initial time of diagnosis. All other histologies of the skin are reportable, i.e.: melanoma, Kaposi sarcoma, mycosis fungoides, cutaneous lymphomas, etc.

| Description | Histology Codes |
|---|---|
| Malignant Neoplasm (Carcinoma), NOS of the skin | 8000 - 8004 |
| Epithelial Neoplasms (Carcinoma), NOS of the skin | 8010 - 8045 |
| Papillary and Squamous Cell Neoplasm (Carcinoma) of the skin | 8050 - 8082 |
| Basal Cell Neoplasm (Carcinoma) of the skin | 8090 - 8110 |

*EXCEPTION:* The above histologies ***MUST*** be reported if the primary site is skin of the male and female genital sites.

| ***Reportable vs Non-Reportable Conditions of the Skin*** | | | | |
|---|---|---|---|---|
| ***ICD-9-CM Code*** | ***Primary Site*** | ***Topography Code*** | ***Reportable*** | ***Non-Reportable*** |
| 184.1 | Skin of Labia Majora | C51.0/ C51.1 | **X** | |
| 184.3 | Skin of Clitoris | C51.2 | **X** | |
| 184.4 | Skin of Vulva | C51.9 | **X** | |
| 187.1 | Skin of Prepuce | C60.0 | **X** | |
| 187.4 | Skin of Penis | C60.9 | **X** | |
| 187.7 | Skin of Scrotum | C63.2 | **X** | |
| 173.0 | Skin of Lip | C44.0 | | **X** |
| 173.1 | Skin of Eyelid/Other Unspecified Parts of Face | C44.1/C44.3 | | **X** |
| 173.2 | Skin of External Ear | C44.2 | | **X** |
| 173.4 | Skin of Scalp and Neck | C44.4 | | **X** |
| 173.5 | Skin of Anus | C44.5 | | **X** |
| 173.5 | Skin of Trunk | C44.5 | | **X** |
| 173.6 | Skin of Upper Limb and Shoulder | C44.6 | | **X** |
| 173.7 | Skin of Lower Limb and Hip | C44.7 | | **X** |
| 173.8 | Skin, Overlapping Lesion | C44.8 | | **X** |
| 173.9 | Skin, NOS | C44.9 | | **X** |

The following conditions are NOT reportable to the Michigan Cancer Surveillance Program.

| *Non-Reportable Conditions* | | | |
|---|---|---|---|
| ***ICD-9-CM Code*** | ***Primary Site*** | ***Histology Code*** | ***Topography Code*** |
| 622.1 | CIN I (cervical intraepithelial neoplasia) with or without mild dysplasia | 8077/0 | C53.0 - C53.9 |
| 622.1 | CIN II (cervical intraepithelial neoplasia) with or without moderate dysplasia | 8077/0 | C53.0 - C53.9 |
| 622.1 | LSIL (low-grade squamous intraepithelial lesion) with or without mild dysplasia | 8077/0 | C53.0 - C53.9 |
| 623.8 | VAIN I (vaginal intraepithelial neoplasia) with or without mild dysplasia | 8077/0 | C52.9 |
| 623.8 | VAIN II (vaginal intraepithelial neoplasia) with or without moderate dysplasia | 8077/0 | C52.9 |
| 624.8 | VIN I (vulvar intraepithelial neoplasia) with or without mild dysplasia | 8077/0 | C51.0 - C51.9 |
| 624.8 | VIN II (vulvar intraepithelial neoplasia) with or without moderate dysplasia | 8077/0 | C51.0 - C51.9 |
| 602.3 | PIN I (Prostatic Intraepithelial Neoplasia) | 8077/0 | C61.9 |
| 602.3 | PIN II (Prostatic Intraepithelial Neoplasia) | 8077/0 | C61.9 |
| 233.4 | PIN III (Prostatic Intraepithelial Neoplasia) | 8077/0 | C61.9 |

***Case Scenarios***
The following scenarios and definitions are to assist with determining whether or not the patient has a reportable condition.

***Reportable Case Scenarios***
1. If a lesion is originally assigned a behavior code of ‘0 - benign’ or ‘1 - uncertain’ and is later assigned a behavior code of ‘2 - in situ’ or ‘3 - malignant’ by the *pathologist*, the case is reportable.

2. If a lesion is originally assigned a behavior code of ‘0 - benign’ or ‘1 - uncertain’ and is later assigned a behavior code of ‘2 - in situ’ or ‘3 - malignant’ by the *managing physician*, the case is reportable.

3. If a specimen is sent to your facility from a staff physician's office and read by your pathologist (i.e. pap smear, stereotatic needle biopsy for a breast mass, or excisional biopsy for a suspicious skin lesion) the case is to be reported.

4. An incidental finding of a malignancy at the time of an autopsy, with no suspicion of cancer prior to death, must be reported.

5. All malignant histologically confirmed specimens identified by your facility, i.e. tissue specimens from biopsy, frozen section, surgery, autopsy, or dilation and curettage (D&C); bone marrow biopsy, bone marrow aspiration; hematologic confirmation of leukemia (peripheral blood smear); loop electrocautery excision procedure (LEEP) done in GYN office.

6. All malignant cytologically confirmed specimens identified by your facility, i.e. breast secretion, bronchial brushing, bronchial washings, cervical smear (pap smear), fine needle aspirate (FNA), gastric fluid, peritoneal fluid, pleural fluid, prostatic secretions, spinal fluid, sputum smears, tracheal washings, urinary sediment, vaginal smears.

7. A patient is diagnosed with a malignancy as an inpatient or outpatient, based upon a clinical or non-microscopic diagnosis where the findings represent a malignancy that is described as probable, presumed, suspected, most likely, consistent with, compatible with, or imposing upon.

8. Patient is diagnosed in a staff physician's office and treated at your facility.

9. Patient is diagnosed at your facility and treated elsewhere, whether by referral or by choice.

10. Patient is diagnosed at your facility and receives all or part of his/her treatment at your facility.

11. Patient is diagnosed at your facility and refuses therapy.

12. Patient is diagnosed at your facility and the family/guardian refuses therapy.

13. Patient is diagnosed at your facility and is untreatable due to age, advanced disease or other medical conditions.

14. Patient is diagnosed at your facility and specific therapy was recommended but not received at your facility or unknown if administered.

15. Patient was diagnosed elsewhere, but received all or part of his/her treatment at your facility.

16. Patient is diagnosed at your facility but unknown if therapy was recommended or administered.

17. Patient was diagnosed by death certificate only.

18. Patient receives all or part of the first course of therapy for a malignancy, regardless of where they were first diagnosed.

19. Patient is a non-resident of Michigan and is receiving treatment at your facility.

20. Patient is a Michigan resident diagnosed out of state but receiving treatment at your facility.

21. Patient is a Michigan resident diagnosed and treated out of state, i.e. The patient is diagnosed and treated in Wisconsin for breast cancer, but is admitted to the cardiac care unit at your facility. You recognize that the patient has breast cancer and is receiving their first course of treatment in Wisconsin. The patient is a Michigan resident, therefore the case is reportable.

***Non-Reportable Case Scenarios***

1. Precancerous or benign conditions (except benign or borderline intracranial CNS tumors).

2. Patients seen only in consultation to establish or confirm a diagnosis of cancer or treatment plan when the patient was first seen in a known Michigan facility.

3. Patient is diagnosed with a recurrence or progression of a previously diagnosed malignancy.

4. The patient's malignancy was originally diagnosed prior to January 1, 1985.

5. Patient receives a radiographic exam (MRI, X-ray, CT) which reveals an ill-defined "mass." If the patient does NOT return to your facility for diagnostic confirmation or treatment of cancer, the case is not reportable. For example: an outpatient CT scan of the pelvis reads, probable carcinoma of the right kidney. The patient did not return to your facility for diagnostic confirmation or treatment; therefore the case is not reportable.

   NOTE: In order for a "radiographic diagnosis" to be reportable, the patient's primary care physician MUST state in the medical record that the patient has cancer and treatment has been decided upon. Keep in mind, that refusal of treatment and the decision not to treat is still classified as treatment and the case is to be reported.

6. Patient has a diagnosis made as an inpatient or outpatient based upon clinical or non-microscopic findings that are described as equivocal, questionable, possible or worrisome.

7. Patient visits your facility for blood work (lab only) and is NOT admitted for treatment, i.e. blood drawn to monitor anemia for patients receiving chemotherapy elsewhere; blood drawn to monitor PSA levels for prostate cancer.

8. Patient has an active malignancy but is admitted to your facility for an unrelated medical condition and does not receive first course of treatment for their cancer.

9. Patient is admitted to your facility with an active malignancy and receives supportive or palliative care, i.e. gastrostomy tubes for enteral nutrition, if previously reported or diagnosed/treated through another Michigan hospital.

10. Patients with a history of cancer who are clinically free of disease.

11. Patients admitted for terminal supportive care, including home care services, if previously reported or diagnosed/treated through another Michigan hospital.

12. Patients admitted to a designated hospice, if previously reported or diagnosed/treated through another Michigan hospital.

13. Patient's specimen slides are sent to your pathologist for a second opinion.

14. Patients with skin cancer that does NOT meet the histology and site requirements listed previously.

***Facility Specific Case Scenario***

Your facility may receive specimens from a separate facility that are read by your pathologist due to the facility not having a pathologist or a laboratory. Once the specimen is read, the final report and specimen(s) are sent back to the original facility. You may or may not be responsible for reporting the ones that are malignancies. A verbal or written contract between the two facilities must exist that designates which facility will be responsible for reporting these cases to the Michigan Cancer Surveillance Program. If an agreement does NOT exist, BOTH facilities are expected to report each case.

## AMBIGUOUS TERMINOLOGY

Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. Sometimes the clinician is hesitant to commit to a definite statement that a particular organ or tissue is involved by the cancer and uses what data collectors refer to as ambiguous terminology. The following lists can generally be used to interpret the intent of the clinician; however, if individual clinicians use these terms differently, the clinician's definitions and choice of therapy should be recognized. If a term used in a diagnostic statement is not listed below, consult the clinician to determine the intent of the statement.

The following terms ARE to be considered a ***diagnosis of cancer or interpreted as evidence*** of tumor involvement when determining the stage of disease.

Adherent
Apparent(ly)
Appears to
Comparable with
Compatible with
Consistent with
Contiguous
Continuous with
Encroaching upon *
Extension to
Extension into
Extension onto
Extension out onto
Features of
Fixation to another structure **
Fixed **
Impending perforation of
Impinging upon
Impose on
Imposing on
Incipient invasion
Induration
Infringe
Infringing
Into *
Intrude
Invasion to into
Invasion onto
Invasion out onto
Most likely
Neoplasm*** (beginning with 2004 diagnoses and only for C70.0-C72.9, C75.1-C75.3)
Onto *
Overstep
Presumed
Probable
Protruding into (unless encapsulated)
Suspect(ed)
Suspicious
To
Tumor*** (beginning with 2004 diagnoses and only for C70.0-C72.9, C75.1-C75.3)
Up to

EXCEPTION: If a cytology is reported as "***suspicious,***" do NOT interpret it as a diagnosis of cancer. Abstract the case ONLY if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

* interpreted as involvement whether the description is clinical, operative or pathological
** interpreted as involvement of another organ or tissue
***additional terms for non-malignant primary intracranial and central nervous system tumors only

The following terms **ARE NOT** to be considered a diagnosis of cancer *or* interpreted as evidence of tumor involvement when determining the stage of disease.

Abuts
Approaching
Approximates
Attached
Cannot be excluded
Cannot be ruled out
Efface/effacing/effacement
Encased
Encasing
Encompass(ed)
Entrapped
Equivocal
Extension to without invasion
Extension to without involvement of
Kiss/kissing
Matted (except for lymph nodes)
Possible
Questionable
Reaching
Rule out
Suggests
Very close to
Worrisome

Ambiguous terms may originate from any source document, such as pathology report, radiology report, or from a clinical report. The terms listed below are grouped by reportable and not reportable

**Ambiguous terms that are reportable** (used to determine reportability)

Apparent(ly)
Appears (effective with cases diagnosed 1/1/1998 and later)
Comparable with (effective with cases diagnosed 1/1/1998 and later)
Compatible with (effective with cases diagnosed 1/1/1998 and later)
Consistent with
Favor(s)
Malignant appearing (effective with cases diagnosed 1/1/1998 and later)
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical (of)

**Ambiguous terms that are NOT reportable** (Do **not accession** cases with a diagnosis based on **only these terms)**

Cannot be ruled out
Equivocal
Possible
Potentially malignant
Questionable
Rule(d) out
Suggests
Worrisome

In an instance where the diagnosis cannot be found in the ICD-O-3 manual, but appears to be an in situ or invasive condition, it is best to report the case or to contact the office for advice.

**Hematopoietic and Lymphoid Neoplasm**
Report the case when the diagnosis of a hematopoietic or lymphoid neoplasm is preceded by one of the following **ambiguous terms.**

***Note***: Do **not** report cases diagnosed only by ambiguous **cytology** (cytology diagnosis preceded by ambiguous term).

Apparent(ly)
Appears
Comparable with
Compatible with
Consistent with
Favor(s)
Malignant appearing
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical (of)

***Note 1***: Reportable diagnoses are described in Case Reportability Instructions 4-10.
***Note 2***: Use these terms when screening all diagnoses other than cytology and tumor markers.
***Note 3***: Report only those cases that use the words on the list or an equivalent word such as "favored" rather than "favor(s)". Do not substitute synonyms such as "supposed" for "presumed" or "equal" for "comparable."
***Note 4***: Accept the reportable term and report the case when one part of the medical record uses a reportable ambiguous term such as "apparently" and another section of the medical record(s) uses a term that is not on the reportable list.

***Refer to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual for further instructions.***

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## CASEFINDING PROCEDURES

Casefinding is a systematic process used to identify all cases eligible to be included in the central cancer registry. Cases include those patients that were diagnosed and/or treated with a reportable condition in your facility.

One source for casefinding is NOT enough to identify all cancer cases diagnosed or treated at your facility and multiple sources MUST be used to obtain a complete description of each patient's course of cancer care.

Each facility should have written procedures and instructions for carrying out complete casefinding. This will ensure that casefinding is performed on a regular basis and allow personnel to know the status of casefinding at all times. A written log or tracking system should be in place to monitor all casefinding sources. Casefinding sources may be monitored daily, weekly, monthly or quarterly.

Having a system for recognizing reportable conditions is essential to complete reporting. A process which will identify all cancer cases that are diagnosed or treated within a facility must be devised. All pertinent medical records which may contain information on any case of diagnosed cancer must be reviewed, whether that diagnosis is clinical or histological. The hospital where a diagnosis is reached or a patient is treated must endeavor to report all cases regardless of the patient's status. This includes outpatients and patients diagnosed elsewhere when the place of diagnosis is unknown or is outside the state. An independent laboratory must similarly ascertain needed information upon determining that a reportable condition exists. It is important to report all patients, <u>including</u> patients who <u>do not</u> live in Michigan.

Patients who were diagnosed elsewhere and newly admitted to your facility for further treatment, are to be reported provided the first diagnosis occurred after the start date of the state registry on January 1, 1985. This may result in multiple reports on one patient, but it will enable the MCSP to have the most comprehensive data on each case and serves as a quality control mechanism.

Reports are necessary for outpatients who are diagnosed as having cancer based upon a laboratory diagnosis of submitted specimens as well as those cases where outpatient surgery is the only means of diagnosis. Outpatients initially treated for cancer who were not diagnosed within a facility should also be reported if receiving outpatient radiotherapy or chemotherapy.

A report is not required when initially treating a patient diagnosed elsewhere **if it is known that the patient was first diagnosed <u>and</u> treated in some other <u>Michigan</u> hospital, and you have the name of the diagnosing hospital in the medical record**. Patients that have been diagnosed out of state e.g. Mayo Clinic or in an unknown facility, who come to your facility for treatment must be reported. This requirement includes the reporting of "historic" cases that otherwise meet the definition of a reportable case.

In many facilities, these functions and/or record systems are coordinated which can greatly simplify the process of case finding. What is important is that all sources of information pertinent to case identification be reviewed. The development of a coordinated screening of these various files is essential to assuring complete reporting.

A second report is not necessary upon confirmation or re-diagnosis of a specific primary tumor or the metastasis therefrom, if that specific primary is known to have been reported earlier. Send a second report

only if the information first reported on the patient requires correction or can be reported more completely than previously known.

It is very important to report all cases regardless of state residency. Data on all cancer cases is of value in several ways. In particular, Michigan currently has resident data exchange agreements with several states concerning cancer cases diagnosed and/or treated within our respective borders. Michigan sends reports of nonresident patients to their state of residency and these states reciprocate by sending MCSP records of MI residents diagnosed or treated for cancer in their state..

When in doubt about submitting a cancer case to the Michigan Cancer Surveillance Program (MCSP), ask these three questions:

1. Does the patient have a diagnosis of cancer that is reportable? Is it a new reportable term?

2. Was the case diagnosed since the start date of the central registry 1-1-85?

If the answer is yes to these questions and the case has not yet been submitted by your hospital, report the case.

If you have questions about a particular case, submit the case with an attached note of explanation or call the state registry.

A record of those cases submitted to the central state registry MUST be maintained. It is recommended for those facilities that submit manually, to make a copy of the completed cancer report, submit the original form to the state central cancer registry and file the copy alphabetically by last name combining all diagnosis years. For those facilities that submit electronically, a list of cases submitted to the state central cancer registry can easily be generated.

The MCSP recommends retaining copies of the cancer report forms or submission log for a period of ***three full years***. Legislation indicates that an audit may be conducted "not more than once every two years for the purpose of assessing the quality and completeness of cancer reporting." During the audit process, the MDI and submission logs are reviewed. As a result, maintaining these records for a period of three years, will be useful during the audit process.

If a submission log is maintained, it should contain at a minimum, the following items: patient's full name, medical record number, social security number, date of birth, date of diagnosis, primary site, laterality and summary stage. The submission log is not necessarily the best mechanism for keeping track of those cases submitted to the MCSP, but those facilities that wish to maintain a log are free to do so.

Examples and definitions of sources for case finding are as follows:

**1. Pathology Reports**
Review ALL pathology reports from the pathology department for reportable conditions on a weekly, monthly or quarterly basis.

If the final pathologic diagnosis is 'CNS neoplasm' or 'mass,' there must be an ICD-O-3 code for the mass or neoplasm. If there is not an ICD-O-3 code, the case is NOT reportable.

If the ONLY diagnosis available is 'CNS tumor' or 'neoplasm' the case is reportable and the histology is coded as M-8000/1 (Neoplasm, NOS, uncertain whether benign or malignant.)

**2. Cytology Reports**
Review ALL cytology reports from the pathology department for reportable conditions on a weekly, monthly or quarterly basis.

**3. Bone Marrow Reports**
Review ALL bone marrow reports from the pathology department for reportable conditions on a weekly, monthly or quarterly basis.

**4. Autopsy Reports**
Review ALL autopsy reports from the pathology department at least twice a year. Review all diagnoses recorded, not just the cause of death, as occult or unexpected malignancies can be found on autopsy reports. If your facility does not perform autopsies, these reports may be located in the health information department.

**5. Medical Oncology Logs (Chemotherapy)**
Chemotherapy is administered either as an inpatient, outpatient, in a free-standing facility or a physician's office. Develop a system for identifying patients who receive chemotherapy at any facility affiliated with the reporting institution. Review the list of patients on a monthly or quarterly basis. i.e. billing, summary sheet, appointment book, treatment record.

**6. Radiation Oncology Logs**
Radiation therapy is administered either as an inpatient, outpatient or in a free-standing facility. Develop a system for identifying patients who receive radiation therapy at any facility affiliated with the reporting institution. Review the list of patients on a monthly or quarterly basis. i.e. billing, summary sheet, appointment book, treatment record.

**7. Radiology**
For benign/borderline intracranial and central nervous system tumors, the terms 'tumor' and 'neoplasm' are considered diagnostic for the purpose of case reporting, in addition to the terms generally applicable to malignant tumors.

Diagnoses like 'hypodense mass' or 'cystic neoplasm' are NOT reportable even for CNS sites.

**8. Master Disease Index (MDI)**
Generate a MDI on a monthly or quarterly basis by discharge date which is based upon the diagnosis year.

Use the ICD-9-CM codes on the following pages to generate the MDI.

Select those patients seen at your facility as an inpatient and/or as an outpatient for surgery, endoscopy, chemotherapy, radiation therapy, etc. (***Exclude laboratory and radiology visits.***)

List the principle code, primary code and secondary codes to include up to ***six*** diagnostic codes that have been assigned.

The MDI should include the following items: last name, first name, middle initial, date of birth, social security number, medical record number, laboratory number (if applicable), admit date, discharge date, patient type, ICD-9-CM code and description.

Sort the MDI ***alphabetically*** by last name. This will make it easier when comparing the MDI to previously submitted cases.

Once the MDI has been generated, it must be compared with the log (or copies) of previously submitted cases.

If the name from the MDI appears on the log of previously submitted cases, determine whether this is a new primary, recurrence or progression of disease from the original primary.

a. A separate report MUST be submitted for each NEW primary.
b. Additional reports for recurrence or progression of disease are NOT required.

If the name from the MDI does NOT appear on the log of previously submitted cases, determine whether this a NEW case, MISSED case or NON-REPORTABLE CONDITION.

a. A separate report MUST be submitted for a new or missed case.
b. If a non-reportable condition exists, document on the MDI next to the patient's name the condition that was determined to be non-reportable. This will be helpful when reviewing future MDI's.

*Examples* John Doe - NR SCC skin (non-reportable squamous cell carcinoma)
James Doe - NR recurrent bladder cancer

Based upon your facility's needs, it may be beneficial to maintain a separate log of those cases determined to be non-reportable. This can easily be achieved by completing the demographic information only on the cancer report form and documenting the non-reportable condition in the primary anatomical site field.

The MCSP recommends retaining the MDI log for a period of ***three full years***. Legislation indicates that an audit may be conducted "not more than once every two years for the purpose of assessing the quality and completeness of cancer reporting." During the audit process, the MDI and submission logs are reviewed. As a result, maintaining these records for a period of three years, will be useful during the audit.

| ICD-9-CM Code | Explanation of Code |
|---|---|
| **140.0 – 208.92** | Malignant Neoplasms |
| **209.00 – 209.29** | Neuroendocrine tumors |
| **209.30** | Malignant poorly differentiated neuroendocrine carcinoma, any site<br>*Reportable inclusion terms:*<br>*High grade neuroendocrine carcinoma, any site*<br>*Malignant poorly differentiated neuroendocrine tumor NOS* |
| **209.31 – 209.36** | Merkel cell carcinoma<br>**Note: Effective date 10/1/09** |
| **209.70 – 209.79** | Secondary neuroendocrine tumors |

| ICD-9-CM Code | Explanation of Code |
|---|---|
| | **Note: Effective Date 10/1/09**<br>*Reportable inclusion terms:*<br>*Secondary carcinoid tumors*<br>**Note: All neuroendocrine or carcinoid tumors specified as secondary are malignant** |
| **225.0 – 225.9** | Benign neoplasm of brain and spinal cord neoplasm |
| **227.3** | Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch)<br>*Reportable inclusion terms:*<br>*Benign neoplasm of craniobuccal pouch, hypophysis, Rathke's pouch or sella turcica* |
| **227.4** | Benign neoplasm of pineal gland |
| **227.9** | Benign neoplasm; endocrine gland, site unspecified |
| **228.02** | Hemangioma; of intracranial structures<br>*Reportable inclusion terms:*<br>*Angioma NOS, Cavernous nevus, Glomus tumor, Hemangioma (benign)* |
| **228.1** | Lymphangioma, any site |
| **230.0 – 234.9** | Carcinoma in situ<br>*Reportable inclusion terms:*<br>*Intraepithelial neoplasia III* |
| **236.0** | Endometrial stroma, low grade (8931/1)<br>*Reportable inclusion terms:*<br>*Stromal endometriosis (8931/3 per ICD-O-3)*<br>*Stromal myosis (endolymphatic) (8931/3 per ICD-O-3)*<br>*Stromatosis, endometrial (8931/3 per ICD-O-3)* |
| **237.0 – 237.9** | Neoplasm of uncertain behavior [borderline] of endocrine glands and nervous system |
| **238.4** | Polycythemia vera (9950/3) |
| **238.6** | Neoplasm of uncertain behavior of other and unspecified sites and tissues, Plasma cells (Plasmacytoma, extramedullary, 9734/3)<br>*Reportable inclusion terms:*<br>*Plasmacytoma NOS (9731/3)*<br>*Solitary myeloma (9731/3)* |
| **238.7** | Other lymphatic and hematopoietic tissues<br>**Note: This code was expanded 10/2006. It is now a subcategory and is no longer valid for use for coding purposes. It should be included in extract programs for quality control purposes.)** |
| **238.71** | Essential thrombocythemia (9962/3)<br>*Reportable inclusion terms:*<br>*Essential hemorrhagic thrombocythemia*<br>*Idiopathic (hemorrhagic) thrombocythemia* |

| ICD-9-CM Code | Explanation of Code |
|---|---|
| **238.72** | Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9983/3, 9985/3)<br>*Reportable inclusion terms:*<br>*Refractory anemia (RA) (9980/3)*<br>*Refractory anemia with excess blasts-1 (RAEB-1) (9983/3)*<br>*Refractory anemia with ringed sideroblasts (RARS) (9982/3)*<br>*Refractory cytopenia with multilineage dysplasia (RCMD) (9985/3)*<br>*Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS) (9985/3)* |
| **238.73** | High grade myelodysplastic syndrome lesions (includes 9983/3)<br>*Reportable inclusion terms:*<br>*Refractory anemia with excess blasts-2 (RAEB-2)* |
| **238.74** | Myelodysplastic syndrome with 5q deletion (9986/3)<br>*Reportable inclusion terms:*<br>*5q minus syndrome NOS* |
| **238.75** | Myelodysplastic syndrome, unspecified (9985/3, 9987/3) |
| **238.76** | Myelofibrosis with myeloid metaplasia (9961/3)<br>*Reportable inclusion terms:*<br>*Agnogenic myeloid metaplasia*<br>*Idiopathic myelofibrosis (chronic)*<br>*Myelosclerosis with myeloid metaplasia* |
| **238.77** | Post transplant lymphoproliferative disorder (9987/3) |
| **238.79** | Other lymphatic and hematopoietic tissues (includes 9960/3, 9961/3, 9970/1, 9931/3)<br>*Reportable inclusion terms:*<br>*Lymphoproliferative disease (chronic) NOS (9970/1)*<br>*Megakaryocytic myelosclerosis (9961/3)*<br>*Myeloproliferative disease (chronic) NOS (9960/3)*<br>*Panmyelosis (acute) (9931/3)* |
| **239.6** | Neoplasms of unspecified nature, brain |
| **239.7** | Neoplasms of unspecified nature; endocrine glands and other parts of nervous system |
| **239.81 – 239.89** | Neoplasms of unspecified nature; other specified sites<br>**Note: Effective Date 10/1/09** |
| **273.2** | Other paraproteinemias<br>*Reportable inclusion terms:*<br>*Franklin's disease (heavy chain) (9762/3)*<br>*Heavy chain disease (9762/3)*<br>*Mu-chain disease (9762/3)* |

| ICD-9-CM Code | Explanation of Code |
|---|---|
| **273.3** | Macroglobulinemia<br>*Reportable inclusion terms:*<br>*Waldenström's macroglobulinemia (9761/3)*<br>*Waldenström's (macroglobulinemia) syndrome* |
| **288.3** | Eosinophilia<br>Note: This code is for eosinophilia, which is not reportable. Do not abstract unless diagnosis is "Hypereosinophilic syndrome (9964/3)." |
| **795.06** | Papanicolaou smear of cervix with cytologic evidence of malignancy |
| **795.16** | Papanicolaou smear of vagina with cytologic evidence of malignancy |
| **796.76** | Papanicolaou smear of anus with cytologic evidence of malignancy |
| **V10.0 – V10.89** | Personal history of malignancy<br>**Note: Screen for recurrences, subsequent primaries, and/or subsequent treatment** |
| **V10.90** | Personal history of unspecified malignant neoplasm<br>**Note: Effective Date: 10/1/09. Screen for recurrences, subsequent primaries, and/or subsequent treatment** |
| **V10.91** | Personal history of malignant neuroendocrine tumor, carcinoid tumor, Merkel cell carcinoma<br>**Note: Effective Date: 10/1/09. Screen for recurrences, subsequent primaries, and/or subsequent treatment** |
| **V12.41** | Personal history of benign neoplasm of the brain |

***BENIGN BRAIN***

Due to a change in the federal law affected by passage of Public Law 107-260, which requires the collection of case information for benign brain and CNS tumors, revisions to the administrative rules that govern Michigan cancer reporting have been made. Reporting of benign brain and CNS related tumors is now required. This new requirement is effective with cases diagnosed on October 1, 2004 forward.

Any tumor diagnosed October 1, 2004 or later with a behavior code of '0' or '1' will be collected for the following site codes based on *The International Classification of Disease Oncology, Third Edition (ICD-O-3)*: meninges (C70.0 – C70.9); brain (C71.0 – C71.9); spinal cord, cranial nerves, and other parts of the central nervous system (C72.0 – C72.9); pituitary gland (C75.1); craniopharyngeal duct (C75.2); and pineal gland (C75.3).

Juvenile astrocytomas should continue to be reported as 9421/3.

| Casefinding List for Benign/Borderline Intracranial and CNS Tumors | | |
|---|---|---|
| **ICD-9-CM** | **ICD-O-3** | **Description** |
| 225.2, 237.6 | C70.0 | Cerebral Meninges |
| 225.2, 237.6 | C70.1 | Spinal Meninges |
| 225.2, 237.6 | C70.9 | Meninges, NOS |
| 225.0, 237.5 | C71.0 | Cerebrum |
| 225.0, 237.5 | C71.1 | Frontal Lobe |
| 225.0, 237.5 | C71.2 | Temporal Lobe |
| 225.0, 237.5 | C71.3 | Parietal Lobe |
| 225.0, 237.5 | C71.4 | Occipital Lobe |
| 225.0, 237.5 | C71.5 | Ventricle, NOS |
| 225.0, 237.5 | C71.6 | Cerebellum, NOS |
| 225.0, 237.5 | C71.7 | Brain Stem |
| 225.0, 237.5 | C71.8 | Overlapping Lesion of Brain |
| 225.0, 237.5 | C71.9 | Brain, NOS |
| 225.3, 237.5 | C72.0 | Spinal Cord |
| 225.3, 237.5 | C72.1 | Cauda Equina |
| 225.1, 237.9 | C72.2 | Olfactory Nerve |
| 225.1, 237.9 | C72.3 | Optic Nerve |
| 225.1, 237.9 | C72.4 | Acoustic Nerve |
| 225.1, 237.9 | C72.5 | Cranial Nerve, NOS |
| 225.8 | C72.8 | Overlapping Lesion of Brain and CNS |
| 225.8, 225.9 | C72.9 | Nervous System, NOS |
| 227.3, 237.0 | C75.1 | Pituitary Gland |
| 227.3, 237.0 | C75.2 | Craniopharyngeal Duct |
| 227.4, 237.1 | C75.3 | Pineal Gland |

## COMPONENTS OF GOOD REPORTING

Quality control field projects carried out within Michigan have been designed to measure the completeness and accuracy of the cancer data as well as timeliness of reporting. The results indicated the following quality control problems that need to be addressed if a facility is to satisfy the obligation to report all cancer cases. These issues are identified separately with recommendations that would help avoid reporting problems. The topics are discussed below and are divided into those that affect case finding and those that affect the accuracy of reports.

### CASEFINDING PROBLEMS

1. Completeness

   Reporting responsibility placed solely in the pathology department results in cases being missed that are diagnosed through other means. This especially pertains to cases involving the primary sites of the trachea, bronchus, pancreas, brain or lung and chronic leukemias/lymphomas.

   In hospitals with no tumor registry there needs to be an established procedure that ensures all cases are reported. These procedures must **include every department in the hospital which deals with cancer patients**. A procedure for reporting should be in place within all departments involved in either diagnosing or treating cancer patients. One approach is to develop a communication system between each department and the group coordinating reporting, placing one person in charge of reporting across all departments. Training staff within each area to follow coordinated procedures will eliminate missing cases. This should be covered within the written procedures on reporting in place within each facility.

2. Registries in Transition

   Hospital cancer registries changing from manual reporting to a software system, or updating to a new software system, tend to have more missing cases. The registry staff while learning the new software system abstracts into the hospital registry while continuing to report manually this can be confusing and can result in cases that need to be sent to the state registry being overlooked.

   During a transition stage **a procedure needs to be developed which will ensure all cases are properly reported**. One approach is to maintain a log of reported cases, or some type of recording system, to allow comparison between the cases in the hospital registry and those cases sent to the central registry. The log needs to be updated and checked on a monthly basis through this transition period.

3. Class of Case

   All approved hospital registries classify cases as analytical or non-analytical. Sometimes registries mistakenly send only the analytical cases. Completeness of reporting is improved by registries being sure they are sending **all cancer patient data regardless of class of case**. Though this may result in duplication, it is the best way to ensure that all cases are reported to the state and none are skipped due to confusion on a patient's status.

   The MCSP accepts all cases regardless of their class of case status.

4. Reporting Outpatient Cases

   Outpatient cases can be overlooked by reporting facilities due to a lack of communication and lack of a reliable reporting system within the facility. It is important to establish a referral procedure that will identify and prompt the reporting of **all outpatient cancer cases which are diagnosed or treated in your facility, clinics operated by your facility or through an affiliated laboratory**.

   Reporting personnel should set up a reporting system with personnel having access to outpatient records relative to outpatient treatment and outpatient diagnosis. It is important to include diagnostic work for specimens submitted to the laboratory in this process. Outpatient cancer case information can be reported independently or, preferably, routed to the personnel responsible for all cancer case reporting. This should be done on a regular basis, i.e. weekly or daily depending upon the size of the hospital, to insure timeliness of reporting and to avoid backlogs.

5. Reporting Michigan Residents Diagnosed Out of State

   Michigan residents diagnosed out of state but receiving treatment in a Michigan hospital can mistakenly not be reported. If a patient has been diagnosed out of state it is important to report the case in all instances. (Michigan does have an exchange agreement with some states to exchange data concerning cancer cases of Michigan residents, but not with all states.) These cases must be reported regardless of the state of diagnosis. **Report all cases treated in your facility that were diagnosed outside Michigan or in an unknown facility.**

6. Reporting Non-residents

   Out of state residents are reportable. Non-resident cases cannot be skipped due to a presumption that only resident cases are necessary. All cancer cases are required to be reported regardless of residency.

   **Report all cases regardless of the patient's address or state of residency.**

7. Referrals to Another Facility

   Cases can be missed if there is a lack of communication between facilities. Especially in instances where a patient was diagnosed at one facility and then referred to a second facility for treatment and each facility assumed that the other had reported the case. The end result was often that neither had reported this case.

   In a situation where hospitals are referring patients, it is recommended that the diagnosing facility and the hospital initially treating the patient **both** report the case. This recommendation applies to clinically diagnosed cases, in particular.

## PRIMARY ANATOMICAL SITE

Record the primary anatomical site where the cancer began or originated

The primary site can be located on the pathology report, attestation statement, discharge summary, surgical report or scans.

*Examples* Bilateral mammogram impression: Development of a 1cm irregularly marginated and slightly spiculated mass in the upper outer quadrant of the right breast, surgical consultation recommended.
Right breast mastectomy: "Infiltrating moderately differentiated ductal cell carcinoma."
*Record the primary site as reported in the mammogram as "breast, UOQ (C50.4)."*

Operative report, right colectomy: Gross description revealed a tan-pink mass 2.5cm in size located at approximately 52cm, in the sigmoid.
Right colectomy: "Infiltrating poorly differentiated mucinous producing adenocarcinoma."
*Record the primary site as reported in the operative report as "sigmoid colon (C18.7)" or "colon, 52cm."*

If the primary site cannot be determined record/code the primary site as "unknown primary site (C80.9)."

Do **NOT** report the metastatic site as the primary site.

*Examples* Fine needle aspiration (FNA) of the liver: "Metastatic adenocarcinoma, possible primary sites to consider include the colon, breast and lung."
Discharge summary: Liver consistent with metastatic adenocarcinoma, primary site not determined.
*Record the primary site as "unknown primary site (C80.9)."*

Left upper lobe bronchoscopy: "Metastatic adenocarcinoma, consistent with breast primary." Subsequently a bilateral mammogram was performed and revealed a poorly defined lesion in the lower outer quadrant of the left breast, suspicious for malignancy.
Discharge summary: Metastatic adenocarcinoma of the lung, consistent with breast primary.
*Record the primary site as "breast, LOQ (C50.5)."*

It is important to be as specific as possible when recording the primary site. Many organs can be sub-divided into specific segments.

*Example* The pathology report indicates adenocarcinoma of the left upper lobe, lung.
*Record the primary site as "lung, upper lobe (C34.1).*"

When recording the primary site, following are examples of sites to be sub-divided. (These are not all the primary sites that can be sub-divided - just a few).

1. Breast

Nipple (areola) (C50.0)
Central portion (subareolar, retroareolar) (C50.1)
Axillary tail (C50.6)
Inner/outer/lower/upper breast, midline (overlapping lesion) (C50.8)

| Right Side | Left Side |
|---|---|
| Upper-inner quadrant (UIQ) (C50.2) (12:00 o'clock to 3:00 o'clock) | Upper-inner quadrant (UIQ) (C50.2) (9:00 o'clock to 12:00 o'clock) |
| Lower-inner quadrant (LIQ) (C50.3) (3:00 o'clock to 6:00 o'clock | Lower-inner quadrant (LIQ) (C50.3) (6:00 o'clock to 9:00 o'clock) |
| Upper-outer quadrant (UOQ) (C50.4) (9:00 o'clock to 12:00 o'clock) | Upper-outer quadrant (UOQ) (C50.4) (12:00 o'clock to 3:00 o'clock) |
| Lower-outer quadrant (LOQ) (C50.5) (6:00 o'clock to 9:00 o'clock) | Lower-outer quadrant (LOQ) (C50.5) (3:00 o'clock to 6:00 o'clock) |

*NOTE 1:* If the pathology report indicates that the mass is located at the 12:00, 3:00, 6:00 or 9:00 position, consider the lesion to be overlapping and code to " breast, overlapping lesion (C50.8)."

*NOTE 2:* If the exact location of the mass is not reported in the operative or pathology report, review the mammogram and/or history and physical examination report for the specific location.

2. Esophagus (C15.0 - C15.9)

The esophagus is a muscular tube about ten inches (25 cm) long extending from the hypopharynx to the stomach. The location of esophageal lesions is frequently measured from the incisors (front teeth) and may be approximated as follows.

| ***Primary Site*** | ***Topography Code*** |
|---|---|
| Cervical - begins at the lower border of the cricoid cartilage and ends at the thoracic inlet (suprasternal notch) approximately 18 cm measuring from the upper incisors | C15.0 |
| Upper thoracic - extends from the thoracic inlet to the level of the tracheal bifurcation, approximately 24 cm from the upper incisors | C15.1 |
| Mid-thoracic - proximal half of the esophagus between the tracheal bifurcation and the esophago-gastric junction. The lower level is approximately 32 cm from the upper incisor teeth | C15.2 |
| Upper third (proximal) - extends from the sixth cervical vertebra to the sixth thoracic vertebra | C15.3 |
| Middle third - extends from the sixth thoracic vertebra to the ninth thoracic vertebra | C15.4 |
| Lower third (distal) - extends from the ninth thoracic vertebra to the cardioesophageal junction | C15.5 |

3. Stomach (C16.0 - C16.9)
The stomach lies just below the diaphragm in the upper part of the abdominal cavity primarily to the left of the midline under a portion of the liver.

| ***Primary Site*** | ***Topography Code*** |
|---|---|
| Cardia - portion of the stomach surrounding the cardioesophageal junction, or cardiac orifice (the opening of the esophagus into the stomach) | C16.0 |
| Fundus (or Fornix) – enlarged portion to the left and above the cardiac orifice | C16.1 |
| Body (or Corpus) - central part of the stomach | C16.2 |
| Pyloric antrum - lower or distal portion above the duodenum; the opening between the stomach and the small intestine is the *pylorus*. | C16.4 |

4. Small Intestine (C17.0 - C17.9)
The small intestine is a tube measuring about 2.5 cm in diameter and over 20 feet (600 cm) in length coiled in loops which fills most of the abdominal cavity.

| ***Primary Site*** | ***Topography Code*** |
|---|---|
| Duodenum - located just below the pyloric portion of the stomach and is about 25 cm long. The duodenum extends from the pyloric sphincter and becomes the jejunum where the tube turns forward and downward. | C17.0 |
| Jejunum - continues for over 200 cm and then becomes the ileum, although there is no demarcation between the two divisions | C17.1 |
| Ileum - over 300 cm long and joins the large intestine at the ileocecal valve | C17.2 |

5. Large Intestine (C18.0 - C20.9)
The large intestine (colon, rectum and anus) is approximately five feet (150 cm) long with a diameter of about 6cm, decreasing towards the lower end. The measurements listed next to each sub-site are from the anal verge.

| ***Primary Site*** | ***Measurement*** | ***Topography Code*** |
|---|---|---|
| Rectum - extends down to the anal canal | 4 - 12 cm | C20.9 |
| Rectosigmoid - upper part of the rectum, generally that above the peritoneal reflection | 10 - 17 cm | C19.9 |
| Sigmoid - joins the rectum at the rectosigmoid junction | 17 - 57 cm | C18.7 |
| Descending (left colon) - starts at the splenic flexure and passes downward until it turns towards the midline at the rim of the pelvis and continues downward to become the sigmoid colon | | |

| *Primary Site* | *Measurement* | *Topography Code* |
|---|---|---|
| | 57 - 82 cm | C18.6 |
| Transverse (middle colon) - begins at the hepatic flexure passing horizontally across the abdomen, below the liver and stomach and above the small intestine. On the left side of the abdomen near the spleen, the colon turns downward at the junction of the transverse and descending colon forming the splenic flexure. | 82 - 132 cm | C18.4 |
| Ascending (right colon) - extends upward from the cecum on the right side of the abdomen to the under surface of the right lobe of the liver where it turns to the left forming the hepatic flexure | 132 - 147 cm | C18.2 |
| Cecum - large cul-de-sac at the lower end of the ascending colon (proximal to the entrance of the ileum into the colon). It comprises the first 5-7 cm of the large intestine. | at 150 cm | C18.0 |
| Hepatic Flexure - connects ascending to transverse (lies under the right lobe of the liver near the duodenum) | | C18.3 |
| Splenic Flexure - connects transverse to descending (located near the spleen and tail of the pancreas) | | C18.5 |
| Anal Canal - constitutes the final 2.5cm of the digestive tract. It begins at the anorectal junction and ends at the anal verge where the anal tube turns outward to blend with the perianal skin. | | C21.1 |

*NOTE:* Each individual's anatomic make-up is different, as such the measurements listed above should be used as a GUIDELINE only.

6. Lung (C34.0 - C34.9)

| *Primary Site* | *Topography Code* |
|---|---|
| Main bronchus (Carina, Hilar) | C34.0 |
| Upper lobe (Apex, Lingual) | C34.1 |
| Middle lobe (only the right lung has a middle lobe) | C34.2 |
| Lower lobe | C34.3 |

5. Lymphoma

***You MUST download the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual from http://seer.cancer.gov/tools/heme/ which applies to only those cases diagnosed January 1, 2010 and forward, to assist with coding this primary.***

Lymphomas are considered a systemic (generalized) disease in contrast to solid tumors, such as breast or stomach cancer. The majority of lymphomas arise in *lymph nodes (C77.0 - C77.9)* or *lymphatic tissue*, such as *tonsils(C09._), spleen (C42.2), Waldeyer's Ring (C14.2), or thymus (C37.9)*. These are all called "nodal" lymphomas.

Lymphomas that arise from lymphatic cells in organs, such as *stomach* or *intestine*, are called extranodal or extralymphatic. The terms extranodal and extralymphatic are sometimes used interchangeably. Extranodal means that the lymphoma does not arise in a lymph node but may arise in one of the lymphatic tissues mentioned above. While extralymphatic means the lymphoma arises in a non-lymphatic organ or tissue. When referring to nodal versus extra nodal lymphomas, it is important to identify the primary site of the tumor, which may not be the site of the biopsy, the site of spread, or metastasis. For example, diffuse large B-cell lymphoma can be either a nodal or extranodal tumor depending on the primary site. The biopsy may be of a lymph node, but the bulk of the primary disease may be in a primary extranodal organ.

If the site of origin of the lymphoma is in the lymph nodes, record/code the primary site to that specific lymph node chain (C77.0 - C77.5).

*Example* A 60 year old female was seen with an enlarged left cervical lymph node that had been present for three months. History and physical examination revealed left cervical lymphadenopathy, and the remainder of examination is within normal limits. Excision of left cervical lymph node revealed: "diffuse large cell non-Hodgkin lymphoma." Staging work-up included a CT scan of the abdomen/pelvis and a bone marrow biopsy, both of which were negative for malignancy.
*Record the primary site as "cervical lymph node (C77.0).*"

If a lymphoma mass is identified as "retroperitoneal," "inguinal," "mediastinal," or "mesentery, " record/code the primary site that specific lymph node region/chain. For example, a retroperitoneal mass would be coded to retroperitoneal lymph nodes C77.2.

If a lymphoma involves multiple lymph node regions, record/code the primary site as "lymph nodes of multiple regions (C77.8)." Do NOT code a specific lymph node chain.

*Example* A 53 year old male relatively healthy and physically active recently noted fatigue and groin soreness. Physical examination revealed several small 1cm nodes in the supraclavicular and axillary areas and two larger 2cm firm inguinal lymph nodes. The rest of the exam was within normal limits. Supraclavicular lymph node biopsy was positive for "B-cell chronic lymphocytic lymphoma."
*Record the primary site as "multiple lymph nodes (C77.8)."*

If a lymphoma arises in an extranodal site, record/code the site of origin, which may or may not be the site of the biopsy.

*Example* Abdominal exploration with biopsy, mass body of stomach: "mixed large and small cell non-Hodgkin lymphoma." CT abd: no lymphadenopathy. *Record the primary site as "body of stomach (C16.2).*"

Record/code "lymph node, NOS (C77.9)" using the following guidelines:

1. When the site of origin is not identified for a lymphoma.

2. A patient has diffuse lymphoma and the primary site is unknown or not specified.

3. Bone marrow metastases are present and the primary site of a lymphoma is unknown or not specified.

*Example* Bone marrow biopsy positive for "diffuse large cell non-Hodgkin lymphoma. CT scan impression: Retroperitoneal mass suspicious for malignancy. *Record the primary site as "retroperitoneal lymph nodes, (C77.2)."*

Record/code mycosis fungoides and cutaneous lymphomas to the appropriate site of the skin (C44.0 - C44.9).

*Example* Patient presented with a large, raised mole on the back of the left arm. A biopsy revealed: "mycosis fungioides." *Record the primary site as "skin, arm (C44.6 ).***"**

*NOTE:* The World Health Organization (WHO) diagnosis of "B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma" is coded as 9823/3, and cross-referenced to 9670/3, "malignant lymphoma, small B lymphocytic." Code to the following scenarios.

If this WHO term is diagnosed in blood or bone marrow record/code the histology as "B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma (9823/3)" and record the primary site as "*bone marrow (C42.1)."*

If this WHO term is diagnosed in tissue, lymph nodes or any organ in combination with blood or bone marrow, record/code the histology as "B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma," which is cross referenced to "small B-Cell lymphocytic lymphoma (9670/3)" and record the primary site to the *"specific lymph node chain (C77.0 -C77.9) or to the extranodal site of origin."*

8. Melanoma of the Skin (C44.0 - C44.9)
Each occurrence of melanoma of the skin is a NEW AND SEPARATE primary unless a physician states otherwise. If a patient is diagnosed with metastatic melanoma and the primary site is not identified, record as "*skin, NOS (C44.9)."*

*Examples* A 46 year old female presented in January 2002, with a skin biopsy positive for "malignant melanoma." Past medical history was positive for malignant melanoma of the right arm in July 2001. Pathology report impression: "skin, right arm positive for malignant melanoma." *Record as a new/separate primary "skin, arm (C44.6)."*

Wide excision skin of mid back: "metastatic malignant melanoma."

Past medical history negative for malignant melanoma. Physical exam revealed scar of mid back from recent excision. Remainder of exam within normal limits, no other skin lesions identified.
*Record the primary site as "skin, NOS (C44.9)."*

9. Kaposi Sarcoma
Code to the *site in which it arises*. If Kaposi sarcoma arises in the skin and another site simultaneously, code to skin.

10. Leukemia (C42.1)
Code the primary site for leukemia as "bone marrow (C42.1)."

11. Multiple Myeloma (C42.1)
Code the primary site for multiple myeloma as "bone marrow (C42.1)."

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## DETERMINING MULTIPLE PRIMARY TUMORS

For both solid tumors and hematopoietic/lymphoid neoplasms, there are specific timing rules determining a new or subsequent primary. You must review the rules for each case to determine if a new primary exists.

***Solid Tumor Rules***

The most recent **SEER Multiple Primary and Histology Coding Rules** contain site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant and nonmalignant brain primaries. A separate set of rules addresses the specific and general rules for all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions.

You must download the complete SEER Multiple Primary and Histology Coding Rules from:
http://seer.cancer.gov/tools/mphrules/2007_mphrules_manual_04302008.pdf

***Hematopoietic and Lymphoid Rules***

The SEER Multiple Primary and Histology Coding Rules do NOT apply to hematopoietic and lymphoid tumors. Use the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** and the **Hematopoietic and Lymphoid Neoplasms Database** to code hematopoietic primaries (lymphoma and leukemia M9590-9989) diagnosed January 1, 2010, or later.

You must download the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic and Lymphoid Neoplasms Database from:
http://seer.cancer.gov/tools/heme/

NOTE: For hematopoietic and lymphoid cases ***diagnosed prior to January 1, 2010,*** you MUST use the Definitions of Single and Subsequent Primaries for Hematologic Malignancies which can download from:
http://seer.cancer.gov/icd-o-3/hematopoietic_primaries.d03152001.pdf.

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## ICD-O-3 SEER Site/Histology Validation List

Specific histologies arise in specific tissue types. Refer to the SEER site/histology validation list to determine valid primary site and histology combinations for cases diagnosed ***on or after*** January 1, 2001.

The Site/Histology Validation List can be downloaded by visiting the SEER website at:

http://www.seer.cancer.gov/icd-o-3/sitetype.icdo3.d20091204.pdf

This insert is intended as a reference for ICD-O-3 only.

Most comparisons can be made to the three-digit histology code but a four-digit histology comparison is required whenever an "!" appears to the left of the three-digit histology name.

To use the SEER site/histology validation list:

a. Locate the three-digit topography code in ICD-O-3, for the primary site in question.

b. Locate the five-digit morphology code in ICD-O-3, for the primary site in question.

c. Locate the three-digit topography code in the SEER site/histology validation list in the left hand column, in numeric order by topography code.

d. Locate the five-digit morphology code in the SEER site/histology validation list in the right hand column, in numeric order by morphology code.

e. If the five-digit morphology code is listed in the right hand column, the site/histologic type is valid.

f. If the five-digit morphology code is NOT listed in the right hand column, the site/histologic type is NOT valid.

    1) Confirm with your pathologist and/or managing physician if the site/histology is valid and code appropriately.

*NOTE:* If the site/histology is valid according to the pathologist and/or managing physician, document this in the text to justify the selected codes. As the purpose of text information is to provide the opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should NOT be generated electronically from coded values.

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## PAIRED ORGANS (LATERALITY)

Laterality (paired organs) at diagnosis describes the primary site ONLY.

0 - Not a paired site
1 - Right side
2 - Left side
3 - One side only, NOS
4 - Bilateral Involvement
5 – Paired Site: midline tumor
9 - Unspecified

Laterality codes "1 - 4 or 9" must be used for the sites listed on the following pages except as noted.

If the primary site is unknown, do NOT code the laterality of the metastatic site, the laterality MUST be coded as "0 - Not a paired site."

If the primary site being reported is NOT defined as a paired organ; laterality MUST be coded as "0 - Not a paired site."

Use code "3 - One side only, NOS" if the laterality is not known but the tumor is confined to a single side of a paired organ.

*Examples* The pathology report states that the "patient has one 2 cm carcinoma in the upper pole of the kidney."
*Code laterality as"3 - One side only, NOS" because laterality is not specified but the tumor is not present on both sides of a paired site.*

*Example* Admitting history states that the patient has a positive, sputum cytology but is being treated with radiation for painful bony metastases.
*Code laterality as "9 - Unknown," because there is no information concerning laterality in the implied diagnosis of lung cancer and the case is metastatic.*

Patient has a melanoma of skin just above the umbilicus.
*Code laterality as "5 - Midline."*

The skin of the lip, scalp and neck is NOT considered a paired organ, laterality for these subcategories MUST be coded as "0 - Not a paired site."

If reporting the primary site of the skin as "skin, NOS (C44.9)" the laterality MUST be coded as "0 - Not a paired site."

*NOTE 1:* The prostate and thyroid are made up of lobes, which are represented by left and right - do NOT code as a paired organ.

*NOTE 2:* The description of right colon and left colon does NOT apply to laterality, but to the exact location (sub-site) of the tumor origin in the colon. Code right colon to ascending colon (C18.2) and the left colon to descending colon (C18.6).

| *List of Paired Organs* | |
|---|---|
| ***Primary Site Description*** | ***Topography Code*** |
| Acoustic nerve | C72.4 |
| Adrenal gland | C74.0 – C74.9 |
| Breast | C50.0 - C50.9 |
| Carotid body | C75.4 |
| Cerebral meninges, NOS (excluding diagnoses prior to 2004) | C70.0 |
| Cerebrum (excluding diagnoses prior to 2004) | C71.0 |
| Connective, subcutaneous and other soft tissue of upper limb and shoulder | C49.1 |
| Connective, subcutaneous, and other soft tissue of lower limb and hip | C49.2 |
| Cranial Nerve, NOS (excluding diagnoses prior to 2004) | C72.5 |
| Epididymis | C63.0 |
| Eye and lacrimal gland | C69.0 – C69.9 |
| Fallopian tube | C57.0 |
| Frontal sinus | C31.2 |
| Kidney, NOS | C64.9 |
| Long bones of lower limb and associated joints | C40.2 |
| Long bones of upper limb, scapula and associated joints | C40.0 |
| Lung | C34.0 – C34.9 |
| Main bronchus (excluding carina) | C34.0 |
| Maxillary sinus | C31.0 |
| Middle ear | C30.1 |
| Nasal cavity (excluding nasal cartilage and nasal septum code ‘0’) | C30.0 |
| Occipital lobe (excluding diagnoses prior to 2004) | C71.4 |
| Olfactory nerve (excluding diagnoses prior to 2004) | C72.2 |
| Optic nerve (excluding diagnoses prior to 2004) | C72.3 |
| Ovary | C56.9 |

| *List of Paired Organs* | |
|---|---|
| ***Primary Site Description*** | ***Topography Code*** |
| Parietal lobe (excluding diagnoses prior to 2004) | C71.3 |
| Parotid gland | C07.9 |
| Pelvic bones (excluding sacrum, coccyx and symphysis pubis, code ‘0’) | C41.4 |
| Peripheral nerves and autonomic nervous system of lower limb and hip | C47.2 |
| Peripheral nerves and autonomic nervous system of upper limb and shoulder | C47.1 |
| Pleura | C38.4 |
| Renal pelvis | C65.9 |
| Rib and clavicle (excluding sternum code ‘0’) | C41.3 |
| Short bones of lower limb and associated joints | C40.3 |
| Short bones of upper limb and associated joints | C40.1 |
| Skin of external ear | C44.2 |
| Skin of eyelid | C44.1 |
| Skin of lower limb and hip | C44.7 |
| Skin of other unspecified parts of face (midline code ‘9’) | C44.3 |
| Skin of trunk (midline code ‘9’) | C44.5 |
| Spermatic cord | C63.1 |
| Sublingual gland | C08.1 |
| Submandibular gland | C08.0 |
| Temporal lobe (excluding diagnoses prior to 2004) | C71.2 |
| Testis | C62.0 – C62.9 |
| Tonsil, NOS (faucial tonsil, palatine tonsil) | C09.9 |
| Tonsil, overlapping lesion | C09.8 |
| Tonsillar fossa | C09.0 |
| Tonsillar pillar | C09.1 |
| Ureter | C66.9 |

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## TUMOR GRADE

The instructions for coding grade and differentiation are found in the "Morphology" section of the ICD-O-3 "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 30–34).

***You MUST download the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual from http://seer.cancer.gov/tools/heme/ to assist with coding the tumor grade for these primaries.***

For sites other than breast, prostate and kidney, code the tumor grade using the following priority order: ***1) terminology; 2) histologic grade; 3) nuclear grade.***

The tumor grade applies to the primary site ONLY.

The grade of a tumor represents the pathological description of the degree to which the tumor tissue resembles normal tissue for that primary site. This is expressed in degrees of differentiation.

Enter the grade or degree of differentiation as stated in the **FINAL** pathologic diagnosis.

If the primary site is reported as "unknown primary site," enter the tumor grade as "9 - Unknown."

Do **NOT** enter the grade of the metastatic(s) site.

If a tumor grade is not given for the primary site, enter the code as "9 - Unknown."

The grade of a tumor, including brain, can be established through magnetic resonance imaging (MRI) or positron emission tomography (PET) when there is no tissue diagnosis.

For primary tumors of the brain and spinal cord (C71.0–C72.9) do not record the WHO grade as the tumor *Grade/Differentiation* (NAACCR Item #440); record the WHO grade in the data item *CS Site-Specific Factor 1* (NAACCR Item #2880).

Grade astrocytomas (M-9383, 9484, 9400, 9401, 9410-9412, 9420, 9421) according to ICD-O-3 rules: I (well differentiated), Code 1; II (intermediate differentiation), Code 2; III (poorly differentiated), Code 3; IV (anaplastic), Code 4.

Do not automatically code glioblastoma multiforme as Grade IV if no grade is given, code 9 (Unknown).

Some primary sites are routinely assigned a grade other than *Grade/Differentiation* (NAACCR Item #440) that is defined by **ICD-O-3**. For the *Grade/Differentiation* item, it is necessary to convert from these systems to *Grade/Differentiation* as described in the following sections.

***Coding Two-grade Systems***

Two grade systems apply to colon, rectosigmoid junction, rectum (C18.0–C20.9), and heart (C38.0). Code these sites using a two-grade system; Low Grade (2) or High Grade (4). If the grade is listed as 1/2 or as Low Grade, then code 2. If the grade is listed as 2/2 or as High Grade, then code 4.

| *Histologic Grade* | *Description* | *Code* |
|---|---|---|
| I/II or 1/2 | Low grade | 2 |
| II/II or 2/2 | High Grade | 4 |

***Coding Three-grade Systems***
Three grade systems apply to peritoneum (C48.1, C48.2), endometrium (C54.1), fallopian tube (C57.0), and brain and spinal cord (C71.0–C72.9). For sites other than breast, prostate and kidney, code the tumor grade using the following priority order: 1) Terminology; 2) Histologic Grade; and 3) Nuclear Grade as shown in the table below.

| *Histologic Grade* | *Description* | *Code* |
|---|---|---|
| I/III or 1/3 | Low grade, well to moderately differentiated | 2 |
| II/III or 2/3 | Medium grade, moderately undifferentiated, relatively undifferentiated | 3 |
| III/III or 3/3 | High Grade, poorly differentiated to undifferentiated | 4 |

*Example* Adenocarcinoma of the sigmoid colon. Grade 2 of 3.
*Code the tumor grade as: 3 - poorly differentiated*

EXCEPTION: Breast cases using the Bloom Richardson grading system; see the following pages "Grading Breast Cases" for further information see page 132.

***Coding Four-grade Systems***
A tumor grade may be described as "1/4" or "I/IV" meaning this is a grade 1 of a four-grade system. To use a four-grade system, code the grade as 1, 2, 3 or 4 respectively.

| *Tumor Grade* | *Description* | *Code* |
|---|---|---|
| I/IV or 1/4 | Well differentiated | 1 |
| II/IV or 2/4 | Moderately differentiated | 2 |
| III/IV or 3/4 | Poorly differentiated | 3 |
| IV/IV or 4/4 | Undifferentiated | 4 |

*Example* Squamous cell carcinoma, Grade 3/4 of the distal esophagus.
*Code the tumor grade as: 3 - poorly differentiated*

The International Classification of Diseases for Oncology (ICD-O) includes, a single-digit code number designating the grade or degree of differentiation of malignant neoplasms. The standard tumor grade codes are as follows:

***Solid Tumors Only***

| *Description* | *Grade/Cell* | *Code* |
|---|---|---|
| Well differentiated; differentiated, NOS | Grade I; grade i; grade 1; | 1 |
| Moderately differentiated; moderately well differentiated; intermediate differentiation | Grade II; grade ii; grade 2; grade I/III; grade 1/3 | 2 |
| Poorly differentiated; dedifferentiated | Grade III; grade iii; grade 3; grade II/III; grade 2/3 | 3 |
| Undifferentiated; anaplastic | Grade IV; grade iv; grade 4; grade III/III; grade 3/3 | 4 |

***Lymphomas and Leukemias Only***

***You MUST download the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual from http://seer.cancer.gov/tools/heme/ which applies to only those cases diagnosed January 1, 2010 and forward, to assist with coding the tumor grade for these primaries.***

| *Description* | *Code* |
|---|---|
| T-cell; T-precursor; T-cell phenotype; Gamma-delta T | 5 |
| B-cell; Pre-B; B-precursor; B-cell phenotype | 6 |
| Null cell; Non-T cell; Non B-cell; Common Cell | 7 |
| NK - Natural Killer Cell | 8 |
| ***Solid Tumors and Hematopoietic and Lymphoid Neoplasms*** | |
| *Description* | *Code* |
| Combined T and B cell; Combined B and NK cell<br>Cell type not determined; Not stated; Not applicable; Unknown Primary | 9 |

Codes "5-7," define T-cell or B-cell origin for leukemias and lymphomas. The terms T-cell, B-cell, Null cell, or Natural killer cell classifications take precedence over any other grading or differentiation. Do NOT use "high grade," "low grade," or "intermediate grade" descriptions for lymphomas as a basis for differentiation. The terms are categories in the Working Formulation of Lymphoma Diagnoses and do NOT relate to the grade.

Do NOT code FIGO grade as a tumor grade. FIGO grade is based on the percentage of non-squamous portions of the tumor and corresponds roughly to a three grade differentiation system. For a diagnosis that includes a term and a FIGO grade, such as "moderately differentiated, FIGO grade II," disregard the FIGO grade and code according to the term "moderately differentiated."

Code the grade or degree of differentiation as stated in the FINAL pathologic description.

| | | |
|---|---|---|
| *Example* | Microscopic Description: | Moderately differentiated squamous cell carcinoma with poorly differentiated areas. |
| | Final Description: | Moderately differentiated squamous cell carcinoma. |
| | *Code the tumor grade as:* | *2 - Moderately differentiated* |

If the grade or degree of differentiation is NOT stated in the final pathologic diagnosis, code the grade or degree of differentiation as given in the microscopic description or comment.

| | | |
|---|---|---|
| *Example* | Microscopic Description: | Poorly differentiated, squamous cell carcinoma, invading the adventitia. |
| | Final Description: | Squamous cell carcinoma, invading the adventitia. |
| | *Code the tumor grade as:* | *3 - poorly differentiated* |

If a diagnosis indicates two different grades or degrees of differentiation code to the numerically higher grade code, even if it does not represent the majority of the lesion.

*Examples* Moderate to poorly differentiated carcinoma.
*Code the tumor grade as: 3 - poorly differentiated*

Predominately grade II, focally grade III.
*Code the tumor grade as: 3 - poorly differentiated*

If a needle biopsy or incisional biopsy of a primary site has a differentiation given and the excision or resection does NOT, code the grade from the biopsy or incisional biopsy.

*Example* Biopsy of sigmoid colon: poorly differentiated adenocarcinoma.
Sigmoidectomy: adenocarcinoma invading the pericolonic tissue.
*Code the tumor grade as: 3 - poorly differentiated*

If there is a difference between the grade given for a biopsy of the primary site and the grade given for the resected specimen, code the numerically higher grade.

*Example* Biopsy of breast: poorly differentiated ductal adenocarcinoma.
Mastectomy: well differentiated ductal adenocarcinoma.
*Code the tumor grade as: 3 - poorly differentiated*

Oftentimes a tumor grade will be described using a slash (/) or a dash (-). The slash describes a specific grading system and the dash describes a range. Code the tumor grade using the slash according to the grading system. Code the tumor grade using the dash to the numerically higher grade code described.

*Examples* Mucinous adenocarcinoma of the rectum, Grade 1/2.
*Code the tumor grade as: 2 – low grade*

Transitional cell carcinoma of the bladder, Grade 1-2/3.
*Code the tumor grade as: 3 - poorly differentiated*

Large cell carcinoma of the lung, Grade 2-3/4
*Code the tumor grade as: 3 - poorly differentiated*

There are several diagnoses that usually do not have a statement as to the tumor grade, therefore the tumor grade is coded as "9 - Unknown." However, if a tumor grade is stated, it MUST be coded. These diagnoses are as follows:

In-situ lesions (any site)
Lobular carcinoma of the breast
Malignant melanoma of the skin
Multiple myeloma (bone marrow)
Unknown primary site

**Brain and Spinal Cord (Malignant)**
Oftentimes, brain and spinal cord diagnoses are assigned a WHO (World Health Organization) grade. This type of grading is **NOT** the same as the ICD-O differentiation or tumor grade code. The WHO grading system is used to estimate prognosis and is for the purpose of staging.

If the ICD-O grade or differentiation code is used for central nervous system tumors, coders should give preference to terms from the diagnosis - such as low grade (Code 2) or anaplastic (Code 4) - rather than using the reported WHO grade. In many cases, there will be no verbal description of the grade and these cases must be coded as "9 - Unknown" for the ICD-O grade or differentiation.

In the absence of other information on grade, code cases as follows:

| ***Description*** | ***Code*** |
|---|---|
| Astrocytoma grade 1 | 1 |
| Astrocytoma grade 2<br>Astrocytoma (low grade) | 2 |
| Astrocytoma grade 3 | 3 |
| Astrocytoma grade 4<br>Anaplastic astrocytoma | 4 |
| Glioblastoma multiforme<br>Pilocytic astrocytoma | 9 |

*Examples* Glioblastoma multiforme of the frontal lobe, WHO grade 3.
*Code the tumor grade as: 9 - unknown*

Pilocytic astrocytoma of the occipital lobe.
*Code the tumor grade as: 9 - unknown*

Anaplastic astrocytoma of the cerebellum.
*Code the tumor grade as: 4 - anaplastic*

Low grade astrocytoma of the cerebrum
*Code the tumor grade as: 2 - low grade*

**Brain and CNS (Benign)**
The tumor grade for benign/borderline intracranial and CNS tumors is ALWAYS coded as a "9 **– not determined, not stated or not applicable**." Do not record the World Health Organization (WHO) grade in the sixth digit of the histology code.

*Example:* Craniopharyngioma, WHO Grade 2
Code as: 9350/1**9**
WHO Grade is recorded in site specific factor 1 as '020.' (see below)

The World Health Organization (WHO) grade should be recorded in site specific factor 1 of the Collaborative Stage Data Collection System Manual (CSv02.03). Attention must be paid to the preservation of histologic grade, which will continue to be collected as the histology sixth digit 'Grade.'

Use the following codes for all benign/borderline intracranial and CNS tumor sites when recording the WHO grade.

| | |
|---|---|
| 010 | WHO Grade I |
| 020 | WHO Grade II |
| 030 | WHO Grade III |
| 040 | WHO Grade IV |
| 999 | Clinically diagnosed/grade unknown; not documented in the medical record; grade unknown, NOS |

EXCEPTION: There is no site specific factor 1 for ***pituitary gland, craniopharyngeal duct*** and ***pineal gland***. Code as '**988 – not applicable**' in site specific factor 1 of the CS system.

**Breast C50.0 – C50.9**
For breast cancers, code the tumor grade using the following priority order:

1) Bloom-Richardson (Nottingham) Scores
2) Bloom-Richardson Grade
3) Nuclear Grade
4) Terminology
5) Histologic

The Bloom-Richardson grading scheme is a semi-quantitative grading method based on three morphologic features of "*invasive no-special-type"* breast cancers. The morphologic features are:

1. degree of tumor tubule formation
2. tumor mitotic activity
3. nuclear pleomorphism of tumor cells (nuclear grade)

To obtain the final Bloom-Richardson score, add the score from the tubule formation, the mitotic activity and the nuclear pleomorphism. There are seven possible scores that are condensed into three BR grades. The three grades then translate into well differentiated (BR low grade), moderately differentiated (BR intermediate grade), and poorly differentiated (BR high grade.)

Use the following table to determine the code when the Bloom Richardson grading scheme is used.

| Bloom Richardson (Nottingham Score) | Bloom Richardson Grade | Nuclear Grade | Terminology | Histologic Grade | Code |
|---|---|---|---|---|---|
| 3-5 points | Low grade | 1/3, 1/2 | Well differentiated | I/III or 1/3 | 1 |
| 6, 7 points | Intermediate grade | 2/3 | Moderately differentiated | II/III or 2/3 | 2 |
| 8, 9 points | High grade | 2/2, 3/3 | Poorly differentiated | III/III or 3/3 | 3 |

*Examples* Ductal carcinoma of the breast, Bloom-Richardson 3 + 2 + 4 = 9
*Code the tumor grade as: 3 - poorly differentiated*

Ductal adenocarcinoma of the breast, Bloom-Richardson, low grade.
*Code the tumor grade as: 1 - well differentiated*

Usually there will be no statement as to the tumor grade for lobular carcinomas of the breast. This is due to the controversy among pathologist when applying the Scarff Bloom-Richardson Grading System. With the lack of architectural criteria and the challenge in obtaining accurate mitotic counts while reading the specimen, it is difficult to assign a tumor grade.

**Kidney C64.9**
For kidney cancers, code the tumor grade using the following priority rules:

1) Fuhrman Grade
2) Nuclear Grade
3) Terminology (well diff, mod. diff.)
4) Histologic Grade.

These prioritization rules do NOT apply to Wilm's tumor (M-8960).

**Lymphoma and Leukemia**
For lymphomas and leukemia, information on T-cell, B-cell, null cell, or NK cell has precedence over information on grading or differentiation.

***You MUST download the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual from http://seer.cancer.gov/tools/heme/ to assist with coding the tumor grade for these primaries.***

Code ANY statement of T-cell, B-cell, null cell, or NK cell involvement whether or not marker studies are documented in the patient record.

For lymphomas, DO NOT code the descriptions "high grade," "low grade," or "intermediate grade" in the Grade, Differentiation, or Cell Indicator field. These terms refer to the categories in the Working Formulation of lymphoma diagnoses and NOT to a histologic grade.

If the tumor grade given is NOT one of the terms listed above, code as "9 - Unknown."

Additional terms for lymphomas and leukemias are as follows:

| ***Description*** | ***Code*** |
|---|---|
| T-cell; T-precursor; T-cell phenotype; Gamma-delta T | 5 |
| B-cell; Pre-B; B-precursor; B-cell phenotype | 6 |
| Null cell; Non-T cell; Non B-cell; Common Cell | 7 |
| NK - Natural Killer Cell | 8 |
| Combined T and B cell; Combined B and NK cell<br>Cell type not determined; Not stated; Not applicable; Unknown Primary | 9 |

*Example* Large diffuse, B-cell lymphoma.
*Code the tumor grade as: 6 - B-cell*

According to the medical understanding on which the World Health Organization (WHO) Classification of Hematopoietic Neoplasms is based, some lymphomas and leukemias are the same disease process with different presentations. The WHO Classification lists B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma (BCCLL/SLL) as a single entity, the same disease at a different stage. The topography or primary site for BCCLL/SLL depends on the location in which the diagnosis was made. Regardless of the primary site, the tumor grade is coded as "6 - B-cell."

**Non-Histology Proven Cases**
When there is not a tissue diagnosis, it may still be possible to establish the grade of a tumor through Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET).

1) If there is no tissue diagnosis, but there is a grade or degree of differentiation available from an MRI or PET report, code the grade based upon these reports.

*Example* MRI of the brain indicated as mass in the temporal lobe. Suspect anaplastic astrocytoma, recommend biopsy.
*Code the tumor grade as: 4 - anaplastic*

2) If there is a tissue diagnosis, grade should be from the pathology report ONLY.

**Prostate C61.9**
Prostate cancers are graded using a Gleason's score or pattern. Gleason's grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer shows two main histologic patterns. The primary pattern - occupying greater than 50% of the cancer - is indicated by the first number of the Gleason's grade and the secondary pattern is indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10.

If only one number is given and it is **greater than 5**, assume that it is a score.

If only one number is given and it is **less than or equal to 5**, assume that it describes a pattern.

If there are two numbers, assume that they refer to two patterns and add the two numbers to obtain the score.

When there are two Gleason Scores present, the highest score takes precedence and should be recorded.

Code the tumor grade using the table below following the priority order:

1) Gleason Score (the sum of the patterns, ie: 2+2=4)
2) Terminology
3) Histologic Grade
4) Nuclear Grade

| ***Gleason's Score*** | ***Histologic Grade*** | ***Description*** | ***Code*** |
|---|---|---|---|
| 2, 3, 4 | I | Well differentiated | 1 |
| 5, 6 | II | Moderately differentiated | 2 |
| 7, 8, 9, 10 | III | Poorly differentiated | 3 |

*Examples* Adenocarcinoma of the prostate, Gleason 4 + 5 = 9.
*Code the tumor grade as: 3 - poorly differentiated*

Adenocarcinoma of the prostate, Gleason 3/10.
*Code the tumor grade as: 1 - well differentiated*

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## DIAGNOSTIC TESTING

Descriptions of procedures performed to determine the method of diagnosis are listed below. A low number takes precedence over all higher numbers regardless of the type of procedure performed.

***Positive Histology***

***Use code 1 for the following methods of diagnoses.***

1. Bone Marrow Biopsy - examination of a piece of bone marrow by puncture or trephine (removing a circular disc of bone) for possible diagnosis of leukemia or multiple myeloma

2. Curettage - removal of growths or other material by scraping with a curette (D&C)

3. Excisional Biopsy - the removal of a growth in its entirety and having a therapeutic as well as diagnostic purpose

4. Frozen Section - a thin slice of tissue cut from a frozen specimen, often used for rapid microscopic diagnosis

5. Hematologic examination - microscopic examination of the cells of the blood or blood-forming tissues (especially bone marrow) for possible diagnosis of leukemia or multiple myeloma

6. Incisional Biopsy - incomplete removal of a growth for the purpose of diagnostic study

7. Punch Biopsy - biopsy of material obtained from the body tissue by a punch technique

8. Surface Biopsy - scraping of cells from surface epithelium, especially from the cervix, for microscopic examination

9. Surgical Biopsy - removal of tissue from the body by surgical excision for examination

***Endoscopic Procedures***

***Use code 1 (histology) if a "piece of tissue" is taken and examined under a microscope.***

***Use code 2 (cytology) if "fluid" is taken and examined under a microscope.***

***Use code 6 (visualization) if no tissue or fluid is taken and a diagnosis of cancer is made.***

*Examples* A patient undergoes a bronchoscopy with a bronchial washing.
*Code the method of diagnosis as: 2 - cytology*

A patient undergoes a colonoscopy with a biopsy of a mass.
*Code the method of diagnosis as: 1 - histology*

1. Bronchoscopy - examination of the bronchi

2. Colonoscopy - examination of the colon and rectum by means of an elongated flexible fiberscope

3. Colposcopy - examination of tissue of the cervix and vagina by use of a magnifying lens inserted into the vagina

4. Culdoscopy - visual examination of the female pelvic viscera by means of an endoscope introduced through the posterior vaginal wall into that part of the pelvic cavity known as the rectovaginal pouch or cul de sac

5. Cystoscopy - examination of the interior of the urinary bladder by means of a cystoscope

6. Esophagoscopy - observation of the interior of the esophagus

7. Gastroscopy - visual examination of the interior of the stomach

9. Laryngoscopy - examination of the larynx

10. Laparoscopy - examination of intra-abdominal structures by means of a illuminated tubular instrument inserted through a small incision in the abdominal wall

11. Mediastinoscopy - examination of the mediastinum by means of a tubular instrument permitting direct inspection of the area between the lungs

12. Nasopharyngoscopy - examination of the nasopharynx, pharynx, and the pharyngeal end of the auditory tube by lighted telescopic endoscope

13. Ophthalmoscopy - an examination in which an instrument containing a perforated mirror and lenses is used to examine the interior of the eye

14. Otoscopy - inspection of the internal ear

15. Panendoscopy - a cystoscopy that permits wide angle viewing of the urinary bladder

16. Peritoneoscopy - examination of the peritoneal cavity by an instrument inserted through the abdominal wall

17. Proctoscopy - inspection of the rectum

18. Sigmoidoscopy - inspection of the colon up to sigmoid flexure

19. Thoracoscopy - direct examination of the pleural cavity by means of an endoscope which is inserted into the cavity through an intercostal space

***Positive Cytology***

***Use code 2 for the following methods of diagnoses.***

1. Aspiration Biopsy - biopsy of material obtained by suction through a needle attached to a syringe

2. Brushings - the procedure of brushing the lining of an organ for the purpose of obtaining cells

3. Fine Needle Aspiration (FNA) - a hollow needle used for withdrawing fluid from a cavity

4. Paracentesis - surgical puncture of a cavity, such as the abdominal cavity, for aspiration of fluid

5. Punctures - inserting a hollow needle into a cavity or organ for the purpose of removal of some portion of the contents

6. Scraping - the procedure of scraping the lining of a structure with an instrument for the purpose of obtaining cells

7. Swab - using a swab or similar device to obtain fluid and secretions which then can be used to make a smear

8. Thoracentesis - surgical puncture for aspiration of fluid from the chest

9. Washings - the removal of fluid from a hollow organ or structure for the purpose of collecting cells

***Visualization***

***Use code 6 for the following method of diagnosis.***

1. Exploratory surgery - surgery is performed to determine whether or not a cancerous condition exists and the degree to which the cancer may have affected other organs and structures within the observed area; no biopsies are taken

***Radiographic Examination***

***Use code 7 for the following methods of diagnoses.***

Radiographic examination refers to a negative image on photographic film made by exposure to x-rays or gamma rays that have passed through matter or tissue.

1. Angiography - radiographic study of the vascular system

    a. cerebral angiogram - x-ray of the vessels of the brain

    b. cardiac angiogram - x-ray showing the functions of the heart and large blood vessels

    c. lymphangiogram - x-ray study of the vessels of the lymphatic system

    d. arteriography - x-ray examination of arteries

    e. venography - x-ray examination of veins

2. Bronchography - radiographic study of the bronchi of the lung

    a. bronchogram - x-ray of the bronchial system

3. Cholecystography - radiologic study of the function of the gallbladder and bile ducts after an opaque medium has been introduced either orally or intravenously

a. cholangiogram - x-ray of extrahepatic ducts

b. cholecystogram - x-ray of the gallbladder

4. Computerized (Axial) Tomography (CT) - examination of body tissue; directs a thin, concentrated beam of radiation through a cross-section of the body to detectors; the technique involves recording of "slices" of the body with an x-ray scanner

5. Hysterosalpingography - radiography of the uterus and fallopian tubes after the injection of radiopaque material

6. Infusion Nephrotomography - radiographic visualization of the kidney by tomography after intravenous introduction of contrast medium

7. Intraoperative Imaging - an imaging procedure such as x-ray, CT scan, ultrasound, or mammogram that is performed during an operative procedure, e.g., to direct a biopsy or to verify the position of a prosthesis

8. KUB (Kidneys, Ureter, Bladder) - a frontal film of the abdomen taken in the supine position

9. Laminography - x-ray of a selected layer of the body; usually performed on joints and eye orbits

10. Lower GI series or Barium Enema - x-ray studies, following rectal injection of barium, of the large bowel; air and barium are used as contrast materials

11. Mammogram - several x-ray views are taken of one or both breasts and the radiographs are examined for the presence of a lesion, mass or calcification

12. Magnetic Resonance Imaging (MRI) - based on magnetization of the various biological tissues; does not use any ionizing radiation (such as x-rays) and is capable of direct imaging in any plane without reformatting

13. Myelography - radiologic study of the spinal cord

14. Positron Emission tomography (PET) - is a unique noninvasive technique that produces three-dimensional images within inside the human body. Compounds like glucose, oxygen, and carbon, which are found naturally in body chemistry, are labeled with signal-emitting tracers and injected into the body. All cells use this tracer, and cells with increased metabolism use more glucose. Because cancer cells are highly metabolic and use more glucose than normal cells, they are easily seen on a PET scan.

15. Radioisotopes - substance administered to patients in order to diagnose disease in which the radioisotopes gather in the infected area emitting gamma rays from within the body which enable the physician to visualize internal abnormalities

16. Salpingography - radiologic study of the uterus and fallopian tubes

17. Sialography - radiologic study of the salivary ducts

18. Thermography - technique for detecting cancer by differentiating regions of hot and cold in the body; the surface temperature is photographically recorded

19. Tomography - a special x-ray technique to show in detail images of structures lying in a predetermined plane of tissue while blurring or eliminating detail in images of structures in other planes; usually performed on the kidneys

20. Upper GI series or Barium Swallow - x-ray studies, following ingestion of barium, of the pharynx, esophagus, stomach, and duodenum

21. Urography - radiologic study of the urinary tract

    a. urogram - x-ray of the kidney and ureter with emphasis on the pelvis of the kidney by intravenous injection of a contrast medium

    b. cystogram - x-ray of the urinary bladder by filling the bladder by catheterization with a contrast medium

    c. IVP (intravenous pyelography) - a succession of x-ray films of the urinary tract following the injection into a vein of an iodine-containing substance which is collected by the kidneys, passing into the ureters and subsequently the bladder, allowing the study of urinary tract function

    d. retrograde urography - examination of the ureter and renal collecting structures by means of instillation of contrast material through a ureteral catheter passed through a cystoscope into the bladder and ureter

22. Ultrasound - high-frequency sound waves; waves can be bounced off of tissues using special devices. The echoes are then converted into a picture called a sonogram. Ultrasound imaging, referred to as ultrasonography, allows physicians and patients to get an inside view of soft tissues and body cavities, without using invasive techniques.

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## SEER SUMMARY STAGE

Use the SEER Summary Staging Manual - 2000, Codes and Coding Instructions for cases diagnosed ***on or after*** January 1, 2001. The summary stage should include all information available through completion of surgery(ies) in the ***first course of treatment or within four months from the date of initial diagnosis***.

Download and print the SEER Summary Staging Manual from http://seer.cancer.gov/tools/ssm/. In addition, go to http://seer.cancer.gov/tools/ssm/errata_08202002.pdf to print off the corrections to the manual; be sure to make the corrections.

Summary staging is a method of organizing extent of disease data into groups which have prognostic significance. A staging system is a reference or chart which indicates the category into which a specific piece of information about a case fits.

Summary stage refers to the primary site ONLY.

Summary stage is required for ALL cases submitted to the Michigan Cancer Surveillance Program.

Summary stage consists of the following categories:

0 - In situ, Intraepithelial, Noninvasive, Noninfiltrating

1 - Localized ONLY (within organ)

2 - Regional by direct extension ONLY (to adjacent organs or tissues)
3 - Regional lymph node(s) involved ONLY
4 - Regional by BOTH direct extension AND regional lymph node(s) involved
5 - Regional, NOS (not otherwise specified)

7 - Distant site(s)/lymph node(s) involved or Systemic Disease

8 - BENIGN: benign brain tumors and central nervous system tumors

9 - Unknown if extension or metastasis (unstaged, unknown or unspecified)
Unknown primary site
Death certificate only case
Class of case 3 or 4 when stage at initial diagnosis is unknown

Summary stage for all sites is based on pathologic, operative and clinical assessments with the pathologic examination taking precedence. It is important to read the pathology and operative reports for evidence of spread, microscopic extension and metastasis, as well as diagnostic imaging reports for mention of distant disease.

Exclude metastasis or disease progression that develops after the four month interval.

Apply the same rules when autopsy reports are used to stage the disease.

If it is not definitively known whether the tumor is in-situ or invasive, the suspected or probable status should be reported.

If the primary site is unknown, the SEER Summary Stage 2000 MUST be coded as "9 - unknown."

The following definitions may be helpful in determining the most appropriate stage.

1. **In Situ ONLY (Code 0)**
   a. in situ means "in place"

   b. presence of malignant cells within the cell group from which they arose

   c. no penetration of the basement membrane of the tissue; no stromal invasion

   d. applies to epithelial tissue only (no such thing as "sarcoma in situ")

   e. if shown to be micro invasive, case is considered localized

   f. the following terms are to be interpreted as in situ:

      Bowen's Disease (not skin)
      CIN III
      Clark's Level I for melanoma
      Hutchinson's melanotic freckle, NOS
      intracystic non-infiltrating
      intraductal
      intra-epithelial
      no penetration of basement membrane of the tissue
      lobular neoplasia
      lobular, non-infiltrating
      non-infiltrating
      non-invasive
      no stromal invasion
      precancerous melanosis
      Queyrat's erythroplasia
      VAIN III
      VIN III

   *Examples* Left breast mastectomy - intraductal carcinoma in LIQ, lymph nodes negative.
   *Code stage as: 0 - in situ*

   Bladder, transurethral resection - noninvasive papillary transitional cell carcinoma, Grade II. There is no invasion seen in the sections examined.
   *Code stage as: 0 - in situ*

2. **Localized ONLY (Code 1)**
   a. malignancy limited to organ of origin

   b. no spread beyond organ of origin

   c. infiltration past basement membrane of epithelium into the functional part of the organ, but no spread beyond the boundaries of the organ

d. tumor can be widely invasive or even show metastasis within the organ itself and still be considered ”confined to organ of origin” or localized

e. usually straightforward stage determination for organs which have definite boundaries (prostate, testis, stomach, etc.) or sites where there is a clear line between the organ of origin and the surrounding region (Exception: skin)

f. for internal organs - it is generally impossible to determine whether the tumor is localized without exploratory surgery

g. if the pathology report, operative report and other investigations show no evidence of spread, tumor may be assumed to be localized

h. when staging cases diagnosed clinically, it is better to record stage as “stage not recorded” rather than “localized” when there is no other evidence of spread

i. recognize the names of different structures within the organ (such as lamina propria, myometrium, muscularis) so that reference to invasion of such structures will not be interpreted as regional spread

*Example*s Subtotal colectomy - ascending colon, moderately differentiated adenocarcinoma invasion through the muscularis propria; no invasion of the pericolic fat; fifteen paracolic lymph nodes negative.
*Code stage as: 1 - localized*

Laryngectomy - squamous cell carcinoma of the glottis invading the true vocal cords, false vocal cords and intrinsic muscles.
*Code stage as: 1 - localized*

NOTE: When the primary site is bone marrow (C42.1) or blood (C42.0), the SEER Summary Stage is either “localized” or “distant” depending upon the histology. Refer to the Hematopoietic and Lymphoid Neoplasm section in the CSv02.03 manual for assistance. As this will include changes in the behavior code for specific diagnoses and alter the stage.

3. **Regionalized (Codes 2, 3, 4, & 5)**

a. tumor extension beyond the limits of the organ of origin

b. area extending from the periphery of an involved organ that lends itself to removal en bloc with a portion of - or an entire - organ with outer limits to include at least the first level nodal basin

c. delineation of the outer limit between regional and distant spread is not always clear

d. en bloc resection may not always be feasible or may have been shown not to be necessary

e. regional stage has several subcategories, each of which is described in detail below along with examples

1. ***regional by direct extension only (code 2)***: invasion through entire wall of organ into surrounding organ and/or adjacent tissues (direct extension or contiguous spread)

*Examples* Radical prostatectomy - invasive adenocarcinoma of the prostate; adenocarcinoma invades into and involves the left seminal vesicle; iliac lymph nodes negative.
*Code stage as: 2 - regional, direct extension*

Radical cystectomy - invasive papillary transitional cell carcinoma of the bladder; carcinoma invading the ureter and prostate; iliac lymph nodes negative.
*Code stage as: 2 - regional, direct extension*

2. ***regional lymph node(s) involved only (code 3)***: tumor invasion of walls of lymphatic where cells can travel through lymphatic vessels to regional lymph nodes where they are filtered out and begin to grow in the nodes

NOTE: Refer to page 284, SEER Summary Staging Manual 2000 for a list of Lymph Node Synonyms.

*Examples* Radical mastectomy - invasive ductal carcinoma of the breast; metastatic adenocarcinoma in one of eleven axillary lymph nodes.
*Code stage as: 3 - regional, lymph nodes*

Radical nephrectomy - invasive renal cell carcinoma; metastatic carcinoma in three of seven renal hilar lymph nodes; biopsy of diaphragm negative.
*Code stage as: 3 - regional, lymph nodes*

3. ***regional by both direct extension and regional lymph node(s) involved (code 4)***: a combination of direct extension and lymph node involvement
Code 2 + Code 3 = Code 4

*Examples* Resection of right colon - moderate to poorly differentiated Grade III/III adenocarcinoma arising from the muscosa, invading into pericolic fat; one of twenty pericolic and mesenteric lymph nodes positive for adenocarcinoma.
*Code stage as: 4 - regional by BOTH direct extension AND lymph node involvement*

Left pneumonectomy - invasive squamous cell carcinoma of the left lung invading the pleura; metastatic carcinoma in two of nine carinal lymph nodes.
*Code stage as: 4 - regional by BOTH direct extension AND lymph node involvement*

4. ***regional, NOS (code 5)***: may be used when it is unclear whether the tissues are involved by direct extension or lymph nodes, or when the other categories are not applicable, such as for staging Non-Hodgkin and Hodgkin Lymphoma of more than one lymph node chain

*Example* Diffuse, large cell, non-cleaved lymphoma involving the mesenteric and ileocolic lymph nodes.
*Code stage as: 5 - regional, NOS*

*NOTE:* Refer to page 277 in the SEER Summary Staging Manual 2000 for a list of the lymph nodes and lymphatic structures above and below the diaphragm.

Clinicians and pathologists use some terms interchangeably which may make it difficult when determining the stage. It is important to understand the words used to describe the spread of cancer.

1. "Local" as in carcinoma of the stomach with involvement of the local lymph nodes. Local nodes are the first group of nodes to drain the primary. Unless evidence of distant spread is present, such a case should be staged as regional, NOT local.

2. "Metastasis" as in carcinoma of lung with peribronchial lymph node metastasis. Metastasis in this sense means involvement by tumor. Such a case would still be regionalized, NOT distant. Learn the regional nodes for each primary site.

4. **Distant site(s)/lymph node(s) or Systemic Disease (Code 7)**

a. tumor cells which have been broken away from the primary tumor, traveled to other parts of the body and have begun to grow at the new location

b. distant stage is also called:
- remote
- disseminated
- diffuse
- metastatic (be careful, this may be regional metastasis)
- secondary disease

c. cancer cells can travel from the primary site in any of four ways:

1. Extension from primary organ beyond adjacent tissue into next organ.

i.e.: lung → pleura → bone

2. Travel in lymph channels beyond the first (regional) drainage area. Tumor cells can be filtered, trapped and begin to grow in any lymph nodes in the body.

i.e.: lung → scalene lymph nodes

3. Hematogenous or blood-borne metastases. Invasion of blood vessels within the primary tumor (veins are more susceptible to invasion than thicker-walled arteries) allows escape of tumor cells or tumor emboli which are transported through the blood stream to another part of the body where it lodges in a capillary or arteriole. At that point the tumor penetrates the vessel wall and grows back into the surrounding tissue.

4. Spread through fluids in a body cavity. Malignant cells rupture the surface of the primary tumor and are released into the thoracic or peritoneal cavity. They float in the fluid and can land on and begin to grow on any tissue reached by the fluid. This type of spread is also called implantation or seeding metastases. Some tumors form large quantities of fluid called ascites that can be removed, but the fluid rapidly re-accumulates.

*NOTE:* The presence of fluid or ascites does not automatically indicate dissemination. There must be cytologic evidence of malignant cells.

d. common sites of spread include *brain, bone, liver and lung*; these organs receive blood flow from all parts of the body. Review the staging scheme for the specific site to make sure disease is not regional extension.

*Examples* Right hemicolectomy - moderately differentiated, Grade I-II/III colonic adenocarcinoma invading into the pericolic fat; eight out of eight pericolic lymph nodes showing reactive lymphoid hyperplasia with no evidence of malignancy; biopsy of a mass on the left ovary shows metastatic moderately differentiated Grade II/III adenocarcinoma consistent with colon primary.
*Code stage as: 7 - distant*

Radical prostatectomy - invasive adenocarcinoma of the prostate; metastatic adenocarcinoma in four of six inguinal lymph nodes.
*Code stage as: 7 - distant*

NOTE: When the primary site is bone marrow (C42.1) or blood (C42.0), the SEER Summary Stage is either 'localized" or "distant" depending upon the histology. Refer to page 280 in the staging manual for a list of the histologies and the appropriate stage.

5. **Unknown if extension or metastasis or Unstaged (Code 9)**

a. for an unknown primary site (C80.9), the summary stage MUST be "9 - Unknown."

b. there will be cases for which sufficient evidence is not available to adequately assign a stage.

*Examples* When a patient expires before workup is completed.
When a patient refuses a diagnostic or treatment procedure.
When there is limited workup due to the patient's age or a simultaneous condition.

c. if sufficient information does not exist, the case can not be staged

d. use unknown stage sparingly - contact the physician to see if there is more information about the case which is not in the record.

e. if sufficient information does not exist, DO NOT guess; there is no choice but to mark the case as unknown.

f. death certificate only cases are coded to "9 - Unknown"

## COLLABORATIVE STAGING

**Refer to site/histology-specific instructions in the *Collaborative Stage Data Collection System Manual* (*CSv02.03 Manual*) for additional information.**

You MUST download the manual from http://www.cancerstaging.org/cstage/ in order to correctly code this field.

Collaborative Stage Data Collection System Manual (CSv02.03) is to be used for cases diagnosed on or after January 1, 2004. It is not to be used for cases diagnosed prior to that date.

Collaborative Staging was designed for registrar use. It relieves registrars from the necessity of staging a single case according to more than one staging system. It avoids most problems that can occur when it is necessary to consider multiple pieces of information simultaneously to assign a single code. For Collaborative Staging, registrars code discrete pieces of information once and the CS computer algorithm derives the values for the 6th and 7th editions of the **AJCC Cancer Staging Manual** T, N, M, Stage Group, and descriptors, as well as Summary Stage 1977 and Summary Stage 2000. The derived stage codes are ideally suited for data analysis because of the consistency that can be obtained with objectively recorded, identically processed data items.

The timing rule for CS coding was designed to make use of the most complete information possible to yield the "best stage" information for the tumor at the time of diagnosis: "use all information gathered through completion of surgery(ies) in first course of treatment or all information available within four months of the date of diagnosis in the absence of disease progression, whichever is longer." Disease progression is defined as further direct extension or distant metastasis known to have developed after the diagnosis was established. Information about tumor extension, lymph node involvement, or distant metastasis obtained after disease progression is documented should be excluded from the CS coding.

The following CS data items are coded by the registrar. Items with an asterisk (*) have site-specific variations for some codes.

*CS Tumor Size* (NAACCR Item #2800) *
*CS Extension* (NAACCR Item #2810) *
*CS Tumor Size/Ext Eval* (NAACCR Item #2820)
*CS Lymph Nodes* (NAACCR Item #2830) *
*CS Reg Lymph Nodes Eval* (NAACCR Item #2840)
*Regional Lymph Nodes Examined* (NAACCR Item #830)
*Regional Lymph Nodes Positive* (NAACCR Item #820)
*CS Mets at DX* (NAACCR Item #2850) *
*CS Mets at DX – Bone* (NAACCR Item #2851)
*CS Mets at DX – Brain* (NAACCR Item #2852)
*CS Mets at DX – Liver* (NAACCR Item #2853)
*CS Mets at DX – Lung* (NAACCR Item #2854)
*CS Mets Eval (NAACCR Item #2860)*
*CS Site-Specific Factors 1-25* (Schema-specific)

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## QUALITY CONTROL

Quality control measures are essential to establish accuracy, completeness and consistency of reporting within the registry. Internal quality control relates to the process that is established to check for errors and discrepancies as reports come into the registry from the reporting facilities. External quality control is a method that checks for errors and discrepancies at the reporting facility.

***NOTE:*** Some of the edit checks are prompts to review unusual data such as a prostate gland cancer in a man less than 45 years of age. If it is something rare, please review it with your pathologist.

### A. INTERNAL QUALITY CONTROL

#### Proper Completion

As the reports are received, they are reviewed for consistency and completeness. Whenever a case is incomplete or inconsistent relative to an essential data item or items the department will query the reporting facility to clarify the case. A copy of the report in question is sent to the reporting facility with a request to clarify or complete the essential data item or items. However, it is customary to make a telephone call rather send out a letter requesting clarification.

Those essential data items and the more common problems that are routinely queried are:

| | |
|---|---|
| Patient's first name | if blank or inconsistent, unknown or illegible |
| Patient's last name | if blank or unknown or illegible |
| Complete address | if blank, illegible or inconsistent |
| Sex | if blank or inconsistent with name or site |
| Date of Birth | if blank or inconsistent with site, report date, or date of diagnosis |
| Social Security Number | if blank |
| Primary site | if blank or inconsistent with histology |
| Laterality | if blank and a paired organ is reported for the primary site |
| Histology | if blank, if inconsistent with the primary site or it indicates the condition may not be reportable |
| Stage | if inconsistent with histology, blank, or, for TNM values, not consistent with the AJCC staging system |
| Method of diagnosis | if blank or inconsistent as in an in situ diagnosis not based upon a microscopic method of diagnosis |

| | |
|---|---|
| Non-diagnostic method | if method of diagnosis is reported as cytology and the case is in-situ, VIN III or CIN III, or a Pap smear, the case will be queried, to determine if a histological confirmation was obtained |
| Treatment | if blank and if the report is from a hospital with a cancer treatment center |

If the reporting facility cannot supply the needed data items requested, the next step is to query the attending physician. For such cases, the complete name and office address of the physician are requested from the reporting facility.

For independent laboratories that do not have access to necessary patient demographic information to complete the report, adding the name and office address of the doctor to the report is extremely helpful. This reference information on the physician should be added to the bottom of the cancer report form for any case with missing information. Be sure to supply the doctor's full name and complete mailing address.

1. Manual checks of new reports

   Routine checking of incoming reports identifies problems early in the processing. Letters are prepared to survey the hospital, laboratory or doctor to obtain information or clarification on identified problems.

   The situations that will result in a letter of inquiry include when:

   a. important information on the patient is missing
   b. the diagnosis is vague or not clearly a malignancy
   c. the diagnosis is an in situ lesion based upon a cytological diagnosis
   d. diagnostic information is missing
   e. logical inconsistencies are evident, such as date of birth that is the same as the date of the report, cancer sites that disagree with the patient's sex or sites and histologies that are not compatible

   If reporting a case that will likely generate a query, such as a CIN III pap smear or a patient with an unknown residence, record the physician's name and address in the lower margin of the report. This information will allow the MCSP staff to contact the doctor directly.

2. Computer edit checks

   A series of edit checks are employed to scan incoming data. Many of these checks are basic screens of the data to insure all codes are valid. Other edits are more complex. These include the standard edit checks for sex and site, site and histology, histology and stage and other edits patterned after those employed at the National Cancer Institute and as recommended by NAACCR. Problems identified by these edits may result in additional inquiries concerning a cancer report.

## B. EXTERNAL QUALITY CONTROL

A quality control field representative will visit each contributing facility to conduct a review of the quality of the cancer reporting at that facility. The field representative will help the facility identify and solve problems associated with case finding, timeliness, abstracting, reporting, etc. Facility staff responsible for submitting reports are encouraged to contact their quality control field representative with questions about cancer reports.

**Facility Audit Procedure**
As a requirement of the legislation governing the Michigan Cancer Surveillance Program, audits will be conducted at all reporting hospitals and laboratories once every three years. If a facility is identified during an audit to have significant problems with quality, completeness and efficiency of reporting, the facility will be audited once a year until they have reached an acceptable level of reporting.

**Selecting Cases for Audit**
A percentage of all accepted cases are re-abstracted in order to assess the accuracy of abstracting and interpretation of data definitions. These cases are selected and re-abstracted without reference to the original abstract. Discrepancies between abstract and re-abstract are discussed by the original abstractor and the field representative. The re-abstracting study is a tool by which the abstractor and the MCSP staff can identify areas of inconsistency and improve the overall reliability of the registry database.

1. The diagnosis year for audit should be the last complete year in which the department has successfully ran through edits. If the last year is incomplete for that specific facility, use discretion when selecting the diagnosis year for audit.

2. Using codes assigned to each case by the MCSP staff, a report is generated by diagnosis year for the facility that is being audited. The report should contain the following information:

a. patient state file number
b. patient full name
c. social security number
d. medical record number
e. topography code
f. year of diagnosis

3. The total number of reportable cases from the reporting facility for a specific diagnosis year is utilized to determine the number of cases to be audited. Select cases for the audit using the following criteria:

a. If the number of reportable cases for a specific diagnosis year is 1 - 400, a minimum of forty (40) cases must be selected for review by MCSP staff.

b. If the facility has less than forty (40) cases for the specific year being audited, combine two years of complete data to reach forty (40) cases.

c. If the number of reportable cases for a specific diagnosis year is 401 - 800, select 10% of the cases for review.

d. If the number of cases for a specific diagnosis year is 801 or more, a maximum of 80 cases will be selected for review.

4. A minimum of thirty (30) cases from a select group of primary anatomical sites will be audited for each facility with less than 300 cases. If the minimum number of cases selected for each assigned primary anatomical site can NOT be reached, select additional cases from the facility's top five sites or other sites such as esophagus, larynx, pancreas, testis or pharynx. This is a recommended baseline and discretion should be used when selecting additional primary anatomical sites. The specific number of cases per primary anatomical site is as follows:

| | |
|---|---|
| a. lymphoma | 3 |
| b. lung | 3 |
| c. prostate | 3 |
| d. colon | 3 |
| e. breast | 3 |
| f. unknown primary | 3 |
| g. urinary bladder | 2 |
| h. leukemia | 2 |
| i. cervix | 2 |
| j. kidney | 2 |
| k. ovary | 2 |
| l. rectum | 2 |
| m. liver | all |
| n. brain | all |
| o. unusual sites | discretion |
| | |
| Total | 30+ |

5. A maximum of 100 cases from a select group of primary anatomical sites will be audited for each facility with more than 1,000 cases. If the maximum number of cases selected for each assigned primary anatomical site can NOT be reached, select additional cases from the facility's top five sites. This is a recommended baseline and discretion should be used when selecting additional primary anatomical sites.

The specific number of cases per primary anatomical site is as follows:

| | |
|---|---|
| a. lymphoma | 10 |
| b. lung | 10 |
| c. prostate | 10 |
| d. colon | 10 |
| e. breast | 10 |
| f. unknown primary | 10 |
| g. urinary bladder | 5 |
| h. leukemia | 5 |
| i. cervix | 5 |
| j. kidney | 5 |
| k. ovary | 5 |
| l. rectum | 5 |
| m. melanoma | 5 |
| n. esophagus | 1 |
| o. larynx | 1 |
| p. pancreas | 1 |
| q. testis | 1 |

| | |
|---|---|
| r. pharynx | 1 |
| s. liver | all |
| t. brain | all |
| u. any unusual site | discretion |
| | |
| Total | 100+ |

6. The facility is mailed a list of the selected cases for review. The list will include at a minimum the following:

a. patient's full name
b. social security number
c. medical record number
d. primary anatomical site
e. month of diagnosis
f. year of diagnosis

7. During the audit, the facility will provide the following:

a. Requested medical records pulled and available prior to the day of the audit.

b. Access to the requested medical records and all information contained in them, as well as any additional medical records that may include further information.

c. Adequate space where the medical records can be reviewed.

d. Access to an outside phone line and power source for a laptop computer.

**Master Disease Index Review**

1. A Master Disease Index (MDI) from the facility for the same diagnosis year as the audit year will be Requested. The ICD-9 codes identified in Sources for Casefinding are used by the facility to generate the master disease index.

2. Patients seen at the facility as an inpatient and/or as an outpatient must be selected. If possible, the facility will eliminate any duplicates that may appear in the listing. If a patient is seen with active or previously diagnosed cancer and is admitted for an *unrelated* medical condition, exclude these patients from the main listing.

3. The MDI will be submitted the MCSP in an Excel file with the following information:

a. patients full name (alphabetical order by last name)
b. date of birth
c. social security number
d. ICD-9-CM diagnostic code
e. admit date
f. discharge date

4. Upon receipt of the file, it will be electronically compared to the cancer registry for complete casefinding.

5. A list identifying the cases that did NOT appear in the registry will be generated. This list will be sent back to the facility for verification of non-reportable conditions.

***Pathology Review***

In addition to the MDI comparison, a total of 120 pathology reports for the specific diagnosis year being audited is required for additional case ascertainment. The pathology reports must be separated into reportable and non-reportable conditions, with the reportable conditions compared to the central cancer registry.

***Data Items Reviewed During the Audit***

| | | |
|---|---|---|
| Name of Patient | Medical Record Number | SEER Summary Stage |
| Street Address, City, Zip | Primary Site | Tumor Size |
| County | Paired Organ | AJCC – TNM Values |
| Social Security Number | Clinical/Histological Diagnosis | AJCC – Stage Group |
| Date of Birth | Cell Behavior | Date Therapy Began |
| Sex | Tumor Grade | Reason No Surgery |
| Race | Date of Diagnosis | Surgery Dates and Codes |
| Hispanic Origin | Method of Diagnosis | First Course of Treatment |

***Results of Data Items Reviewed***

The data items reviewed having a discrepancy are categorized as either a major or minor discrepancy. The major and minor discrepancies are based upon the standards set forth by the North American Association of Central Cancer Registrars (NAACCR). For further information on the standards, refer to Appendix C in the Standards for Cancer Registries Volume III, Standards for Completeness, Quality, Analysis and Management of Data, September 2000.

The number of major and minor discrepancies, are entered into a weighted error discrepancy rate table. Weighting the rate acts as if each and every record submitted was reviewed during the audit. The following is a statistical summary of the weighted error rates along with the major and minor discrepancies identified for each data item reviewed.

The following table represents those data items that are reviewed during audit and which category (major vs minor) they are assigned to. In addition, the required percentage of accuracy is identified which entitles the facility to obtain a Gold or Silver certificate from the Michigan Cancer Surveillance Program.

| Level of Accuracy Required | | | |
|---|---|---|---|
| ***Data Item*** | ***Gold*** | ***Silver*** | ***MCSP Certification*** |
| **Completeness** *(major discrepancy)* | 95% | 90-94% | X |
| **Name of Patient** | | | Not Established |
| *Major (incorrect name submitted)* | | | |
| *Minor (incorrect spelling)* | | | |
| **Patient Demographics:** | | | |
| *Major (county, state)* | 99% | 98% | X |
| *Minor (street address, city, zip)* | 95% | 90% | X |
| **Marital Status** *(minor discrepancy)* | | | Not Established |
| **Social Security Number** *(major discrepancy)* | | | Not Established |
| **Date of Birth** *(major discrepancy)* | 99% | 98% | X |
| **Sex** *(major discrepancy)* | 99% | 98% | X |
| **Race** *(major discrepancy)* | 99% | 98% | X |
| **Hispanic Origin** *(minor discrepancy)* | | | Future Certification |
| **Medical Record Number** *(minor discrepancy)* | | | Not Established |
| **Primary Site** | | | |
| *Major (difference in first three digits)* | 98% | 95-97% | X |
| *Minor (difference in third digit)* | 90% | 85-89% | X |
| **Paired Organs** *(minor discrepancy)* | 99% | 98% | X |
| **Histology** | | | |
| *Major (difference in first three digits)* | 96% | 92-95% | X |
| *Minor (difference in fourth digit)* | 85% | 80-84% | X |
| **Cell Behavior** *(major discrepancy)* | 99% | 98% | X |
| **Tumor Grade** *(minor discrepancy)* | 95% | 90-94% | |
| **Date of Diagnosis** | | | |
| *Major (different year, difference > 1 month)* | 99% | 98% | X |
| *Minor (same calendar year, but difference of 1 month)* | 93% | 90-92% | X |
| **Method of Diagnosis** | | | |
| *Major (1-4 versus 5-9)* | 99% | 98% | X |

| Level of Accuracy Required | | | |
|---|---|---|---|
| ***Data Item*** | ***Gold*** | ***Silver*** | ***MCSP Certification*** |
| *Minor (difference in code within 1-4 or 5-9)* | 97% | 96% | X |
| **General Summary Stage** *(major discrepancy)* | 85% | 75% | Future Certification |
| **Tumor Size** *(minor discrepancy)* | | | Future Certification |
| **AJCC - TNM Values** *(major discrepancy)* | | | Not Established |
| **AJCC - Stage Group** *(major discrepancy)* | | | Not Established |
| **Date Therapy Began** | | | |
| *Major (difference > 1 month, no date versus date,* | 98% | 97% | |
| *unknown versus known month or year)* | | | |
| *Minor ( difference < 1 month)* | 96% | 95% | |
| **Reason No Surgery** | | | |
| *Major (0,8,9 versus 1-7)* | | | Not Established |
| *Minor (0 versus 8-9 or difference in code 1-7)* | | | Not Established |
| **Surgery Code** | | | |
| *Major (no code versus code)* | 98% | 97% | |
| *Minor (difference in code)* | 96% | 95% | |
| **Treatment Summary** | | | |
| Biological Response Modifier | | | |
| Chemotherapy | | | |
| Immunotherapy | | | |
| Radiation | | | |
| *Major (no code or unknown versus code)* | *95%* | *94%* | |
| *Minor (difference in code)* | *93%* | *92%* | |

## DATA SERVICES PROVIDED TO FACILITIES

A variety of services are available to Michigan facilities providing cancer patient information to the Michigan Cancer Surveillance Program. These services are made available to support the research and planning efforts that facility staff determine are necessary and are particularly intended to aid in hospital cancer registry management and associated activities.

The key services available include:

- Hospital Specific Data or Listings
- Ad Hoc Statistical Data
- Death Searches - Death Certificates
- Death Indexes
- Microfich - from 1985 - 1995 (135mm)
- Data Files - from 1996 to current
- Death Notices when Reported Patients Die (includes deaths in Michigan and for many other states.)

For more information on these special services contact:

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## ABBREVIATIONS

| | |
|---|---|
| ACoS | American College of Surgeons |
| ACS | American Cancer Society |
| CA | carcinoma/cancer |
| CNS | central nervous system |
| CSv02.03 | Collaborative Stage Data Collection System Manual (CSv02.03) |
| DX | diagnosis |
| F/U | follow-up |
| H&P | history & physical |
| H/O | history of |
| HX | history |
| ICD-9-CM | International Classification of Diseases - 9th revision Clinical Modification |
| ICD-O-3 | International Classification of Diseases for Oncology, 3rd Edition |
| INPT | inpatient |
| MCSP | Michigan Cancer Surveillance Program |
| MDCH | Michigan Department of Community Health |
| N/A | not applicable |
| NED | no evidence of disease |
| NCI | National Cancer Institute |
| NOS | not otherwise specified |
| NR | not reported |
| Outpt | outpatient |
| PE | physical examination |
| QC | quality control |
| R/O | rule out |
| Rx | treatment |
| SEER | surveillance, Epidemiology and End Results |
| Surg | surgery, surgical |

| | |
|---|---|
| TNM | Tumor, Node, Metastases (staging system of American Joint Committee for Cancer |
| TR | Tumor Registry |
| UNK | unknown |
| WHO | World Health Organization |

## GLOSSARY OF TERMS

| | |
|---|---|
| Abstract | A summary of a medical case history containing pertinent portions of the medical record. |
| Anatomic Site | Pertaining to anatomy, or to the structure of the organism. |
| Autopsy | The post mortem examination of a body. |
| Basal Cell | The predominant cell of the deepest layer of the epidermis. |
| Benign | Not malignant; not recurrent; favorable for recovery. |
| Bilateral Organs | Anatomic organs that exist on both sides of the body. |
| Biopsy | The removal and examination, usually microscopic, of tissue, performed to establish the characteristics of the neoplasm. |
| Blastoma | A neoplasm composed of embryonic cells. |
| Cancer | A malignant tumor. |
| Carcinoma | A malignant new growth made up of epithelial cells tending to infiltrate the surrounding tissues and give rise to metastases. |
| Case-Finding | Systematic identification of all reportable neoplasm cases in a facility. |
| Clinical Cases | Cancer cases not microscopically confirmed through biopsy. |
| Cytology | The microscopic examination of cells obtained by aspirations, washings, scrapings, and smears (such as pap smears). |
| Date of Diagnosis | Refers to the first diagnosis of the cancer by a recognized medical practitioner. This is usually the date of first positive tissue specimen. |
| Demography | The study of populations, especially with reference to size and density, fertility, mortality, growth, age distribution, migration and vital statistics, and the interaction of all these with social and economic conditions. |
| Diagnosis | The determination of the nature of disease. |
| Diagnosis Index | A listing of cases by date of discharge from the hospital arranged in diagnostic groupings according to a specific coding system. |
| Endothelium | The layer of epithelial cells that lines the cavities of the heart and of the blood and lymph vessels, and the serous cavities of the body. |
| Epidemiology | The study of the occurrence and distribution of disease. |

| | |
|---|---|
| Epithelium | The covering of internal and external surfaces of the body. |
| Exfoliative Cytology | Microscopic examination of cells shed from a body surface as a means of detecting malignant change. |
| Frozen Section | A slice cut by a special instrument, the microtome, from tissue that has been frozen. |
| Gross Anatomy | That which deals with structures that can be distinguished with the naked eye, also called macroscopic anatomy. |
| Gross Observation | Observations seen with the naked eye (see gross anatomy). |
| Hematology | The science of blood, its nature, functions, and diseases. |
| Histology | The specialty of anatomy which deals with minute structures. |
| Laterality | A relationship to one side, denoting a position from the midline of the body. |
| Lesion | Any pathological or traumatic discontinuity of tissue or loss of function of a part. |
| Leukemia | A progressive, malignant disease of the blood-forming organs. |
| Lymphoma | A term used to describe any neoplastic disorder of the lymphoid tissue, including Hodgkin's disease. |
| Malignant | An uncontrolled, invasive growth capable of metastasizing, spreading to tumor a distant part of the body. Opposite of benign. |
| Microscopic Confirmation | The process of confirming the diagnosis of a neoplasm by examination of tissue through a microscope. |
| Morbidity | Any departure from a state of physiologic or psychological well-being. |
| Morphology | The science of the forms and structure of organized beings. |
| Myeloma | A tumor composed of cells of the type normally found in the bone marrow. |
| Neoplasm | A new growth. |
| Oncology | The sum of knowledge concerning tumors; the study of tumors. |
| Paired Site | See bilateral organs. |
| Papillary | Pertaining to or resembling a papilla, or nipple. |
| Pathology | That branch of medicine which treats the essential nature of disease, especially of the structural and functional changes in tissues and organs of the body which cause or are caused by disease. |

| | |
|---|---|
| Peritoneal Fluid | Fluid from the serous membrane lining the abdominopelvic walls and the viscera. |
| Pleural Fluid | Fluid from the serous membrane enveloping the lungs and lining the thoracic cavity, completely enclosing a potential space known as the pleural cavity. |
| Primary Site | The anatomic organ or tissue of the body where a cancer originates. |
| Rates | |
| Incidence Rate | The number of new cases of a disease occurring in a period of time divided by the number of persons at risk of becoming a case during that time. The result is frequently multiplied by a base number such as 1,000 or 100,000. |
| Death Rate | Computed in the same manner as an incidence rate except that deaths during the time period are used instead of new cases. The deaths may be for a specific cause or causes. |
| Mortality Rate | See death rate. |
| Specific Rates | |
| Age | An incidence or death rate calculated using data (cases, deaths, persons at risk) for a specific age group rather than for all ages. |
| Sex | An incidence or death rate calculated using data for one sex only. |
| Resection | Removal of a portion of an organ or other structure. |
| Sarcoma | A tumor made up of a substance like embryonic connective tissue. |
| Smear | A specimen for microscopic study prepared by spreading the material across a glass slide. |
| Tissue Specimen | A preparation of tissue for pathological examination. |
| Tumor | Classically means a swelling or mass; in current usage means a new growth of tissue or cells. |
| Validity | The closeness with which a measured value agrees with the "true" value which one desires to know. |

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**FIPS County Codes for Use Beginning in 1997**

| | | | |
|---|---|---|---|
| Alcona | 001 | Leelanau | 089 |
| Alger | 003 | Lenawee | 091 |
| Allegan | 005 | Livingston | 093 |
| Alpena | 007 | Luce | 095 |
| Antrim | 009 | Mackinac | 097 |
| Arenac | 011 | Macomb | 099 |
| Baraga | 013 | Manistee | 101 |
| Barry | 015 | Marquette | 103 |
| Bay | 017 | Mason | 105 |
| Benzie | 019 | Mecosta | 107 |
| Berrien | 021 | Menominee | 109 |
| Branch | 023 | Midland | 111 |
| Calhoun | 025 | Missaukee | 113 |
| Cass | 027 | Monroe | 115 |
| Charlevoix | 029 | Montcalm | 117 |
| Cheboygan | 031 | Montmorency | 119 |
| Chippewa | 033 | Muskegon | 121 |
| Clare | 035 | Newaygo | 123 |
| Clinton | 037 | Oakland | 125 |
| Crawford | 039 | Oceana | 127 |
| Delta | 041 | Ogemaw | 129 |
| Dickinson | 043 | Ontonagon | 131 |
| Eaton | 045 | Osceola | 133 |
| Emmet | 047 | Oscoda | 135 |
| Genesee | 049 | Otsego | 137 |
| Gladwin | 051 | Ottawa | 139 |
| Gogebic | 053 | Presque Isle | 141 |
| Grand Traverse | 055 | Roscommon | 143 |
| Gratiot | 057 | Saginaw | 145 |
| Hillsdale | 059 | St. Clair | 147 |
| Houghton | 061 | St. Joseph | 149 |
| Huron | 063 | Sanilac | 151 |
| Ingham | 065 | Schoolcraft | 153 |
| Ionia | 067 | Shiawassee | 155 |
| Iosco | 069 | Tuscola | 157 |
| Iron | 071 | Van Buren | 159 |
| Isabella | 073 | Washtenaw | 161 |
| Jackson | 075 | Wayne | 163 |
| Kalamazoo | 077 | Wexford | 165 |
| Kalkaska | 079 | Out of State | 998 |
| Kent | 081 | Unknown | 999 |
| Keweenaw | 083 | | |
| Lake | 085 | | |
| Lapeer | 087 | | |

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**NAACCR Standard State Codes**

**Postal Codes** for Residence State
**SEER Codes** for Birth Place

| State | Residence | Birth Place | State | Residence | Birth Place |
|---|---|---|---|---|---|
| Alabama | AL | 037 | Rhode Island | RI | 006 |
| Alaska | AK | 091 | South Carolina | SC | 026 |
| Arizona | AZ | 087 | South Dakota | SD | 055 |
| Arkansas | AR | 071 | Tennessee | TN | 031 |
| California | CA | 097 | Texas | TX | 077 |
| Colorado | CO | 083 | Utah | UT | 084 |
| Connecticut | CT | 007 | Vermont | VT | 004 |
| Delaware | DE | 017 | Virginia | VA | 023 |
| District of Columbia | DC | 022 | Washington | WA | 093 |
| Florida | FL | 035 | West Virginia | WV | 024 |
| Georgia | GA | 033 | Wisconsin | WI | 051 |
| Hawaii | HI | 099 | Wyoming | WY | 082 |
| Idaho | ID | 081 | Puerto Rico | PR | 101 |
| Illinois | IL | 061 | Virgin Island | VI | 102 |
| Indiana | IN | 045 | Guam | GU | 126 |
| Iowa | IA | 053 | American Samoa | AS | 121 |
| Kansas | KS | 065 | Alberta | AB | 224 |
| Kentucky | KY | 047 | British Columbia | BC | 226 |
| Louisiana | LA | 073 | Northwest Ter. | NT | 225 |
| Maine | ME | 002 | Manitoba | MB | 224 |
| Maryland | MD | 021 | New Brunswick | NB | 221 |
| Massachusetts | MA | 005 | Newfoundland | NF | 221 |
| Michigan | MI | 041 | Nova Scotia | NS | 221 |
| Minnesota | MN | 052 | Ontario | ON | 223 |
| Mississippi | MS | 039 | Prince Edward Is. | PE | 221 |
| Missouri | MO | 063 | Québec | PQ | 222 |
| Montana | MT | 056 | Saskatchewan | SK | 224 |
| Nebraska | NE | 067 | Yukon | YT | 225 |
| Nevada | NV | 085 | Rest of World | XX | *** |
| New Hampshire | NH | 003 | Unknown | YY | 999 |
| New Jersey | NJ | 008 | | | |
| New Mexico | NM | 086 | | | |
| New York | NY | 011 | | | |
| North Carolina | NC | 025 | | | |
| North Dakota | ND | 054 | | | |
| Ohio | OH | 043 | | | |
| Oklahoma | OK | 075 | | | |
| Oregon | OR | 095 | | | |
| Pennsylvania | PA | 014 | | | |

*** For other Place of Birth Codes see Place of Birth Coding Listing

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## ALPHABETICAL LISTING OF COUNTRIES

* *Effective cases diagnosed 1/1/1992.*

### A

585 Abyssinia
629 Aden
583 Afars and Issas
638 Afghanistan
500 Africa
570 Africa, East
510 Africa, North
540 Africa, South
545 Africa, South West
530 Africa, West
580 African Coastal Islands (previously included in 540)
037 Alabama
091 Alaska
481 Albania
224 Alberta
513 Algeria
250 America, Central
265 America, Latin
260 America, North (use a more specific term; see also North America)
300 America, South
121 American Samoa
611 Anatolia
641 Andaman Islands
443 Andorra
520 Anglo-Egyptian Sudan
543 Angola
245 Anguilla
665 Annam
750 Antarctica
245 Antigua
245 Antilles, NOS
245 Antilles, Netherlands
625 Arab Palestine (former)
629 Arabia, Saudi
629 Arabian Peninsula
365 Argentina
087 Arizona
071 Arkansas
611 Armenia (Turkey)
633 Armenia (U.S.S.R.)
245 Aruba
600 Asia, NOS*
680 Asia, East
640 Asia, Mid-East
611 Asia Minor, NOS
610 Asia, Near-East
650 Asia, Southeast
620 Asian Arab Countries
634 Asian Republics of the former U.S.S.R.
109 Atlantic/Caribbean area, other U.S. possessions
100 Atlantic/Caribbean area, U.S. possessions
711 Australia
711 Australian New Guinea
436 Austria
633 Azerbaijan
633 Azerbaizhan S.S.R.
445 Azores

### B

247 Bahamas, The
629 Bahrain
443 Balearic Islands
463 Baltic Republic(s), NOS
463 Baltic States, NOS
645 Bangladesh
245 Barbados
245 Barbuda
545 Basutoland
431 Bavaria
545 Bechuanaland
457 Belarus
541 Belgian Congo
433 Belgium
252 Belize
539 Benin
246 Bermuda
456 Bessarabia
643 Bhutan
539 Bioko (Fernando Poo)
452 Bohemia
355 Bolivia
545 Bophuthatswana
673 Borneo
453 Bosnia-Herzogovina
545 Botswana
341 Brazil
226 British Columbia
331 British Guiana
252 British Honduras
245 British Virgin Islands
245 British West Indies, NOS
671 Brunei
454 Bulgaria

520 Burkina Faso (Upper Volta)
649 Burma (see Myanmar)
579 Burundi
457 Byelorussian S.S.R.

**C**

543 Cabinda
245 Caicos Islands
097 California
663 Cambodia
539 Cameroon
220 Canada
110 Canal Zone
443 Canary Islands
122 Canton Islands
545 Cape Colony
445 Cape Verde Islands
245 Caribbean, NOS
245 Caribbean Islands, other
123 Caroline Islands
711 Cartier Islands
633 Caucasian Republics of the former U.S.S.R.
245 Cayman Islands
500 Central Africa, NOS
539 Central African Republic
250 Central America
499 Central Europe, NOS
060 Central Midwest States
647 Ceylon (see Sri Lanka)
520 Chad
401 Channel Islands (British)
361 Chile
681 China, NOS
665 China, Cochin
682 China, People's Republic of
684 China, Republic of
723 Christmas Island
545 Ciskei
665 Cochin China
711 Cocos (Keeling) Islands
311 Colombia
083 Colorado
580 Comoros
226 Columbia, British
022 Columbia, District of
539 Congo, NOS
539 Congo-Brazzaville
541 Congo-Leopoldville
541 Congo, Belgian
539 Congo, French
541 Congo Kinshasa
007 Connecticut
124 Cook Islands
441 Corsica
256 Costa Rica
539 Cote d'Ivoire (Ivory Coast)
471 Crete
453 Croatia
241 Cuba
245 Curacao
495 Cyprus
517 Cyrenaica
452 Czechoslovakia
452 Czech Republic

**D**

539 Dahomey
453 Dalmatia
017 Delaware
425 Denmark
022 District of Columbia
583 Djibouti
449 Dobruja
245 Dominica
243 Dominican Republic
673 Dutch East Indies
332 Dutch Guiana

**E**

570 East Africa
680 East Asia
431 East Germany
673 East Indies, Dutch
645 East Pakistan
499 Eastern Europe, NOS
345 Ecuador
519 Egypt
410 Eire
254 El Salvador
125 Ellice Islands
122 Enderbury Islands
401 England
122 Enterbury Islands
500 Equatorial Africa, NOS
539 Equatorial Guinea (Spanish Guinea)
585 Eritrea
458 Estonia
458 Estonian S.S.R. (Estonia)
585 Ethiopia
499 Europe, NOS*
470 Europe, other mainland

**F**

425 Faroe (Faeroe) Islands
381 Falkland Islands
431 Federal Republic of Germany
123 Federated States of Micronesia
539 Fernando Poo
721 Fiji
429 Finland
035 Florida
684 Formosa
441 France
545 Free State (Orange Free State)
539 French Congo
333 French Guiana
725 French Polynesia
583 French Somaliland
530 French West Africa, NOS
245 French West Indies
721 Futuna

**G**

539 Gabon
345 Galapagos Islands
539 Gambia, The
631 Gaza Strip
033 Georgia (U.S.A.)
633 Georgia (U.S.S.R.)
431 German Democratic Republic
430 Germanic Countries
431 Germany
431 Germany, East
431 Germany, Federal Republic of
431 Germany, West
539 Ghana
485 Gibraltar
122 Gilbert Islands
471 Greece
210 Greenland
245 Grenada
245 Grenadines, The
245 Guadaloupe
126 Guam
251 Guatamala
401 Guernsey
331 Guiana, British
332 Guiana, Dutch
333 Guiana, French
539 Guinea
539 Guinea-Bissau (Portuguese Guinea)
539 Guinea, Equatorial
—— Guinea, New (see New Guinea)
539 Guinea, Portuguese
331 Guyana

**H**

242 Haiti
099 Hawaii
432 Holland
253 Honduras
252 Honduras, British
683 Hong Kong
475 Hungary

**I**

421 Iceland
081 Idaho
061 Illinois
641 India
045 Indiana
673 Indies, Dutch East
660 Indochina
673 Indonesia
053 Iowa
637 Iran
627 Iraq
620 Iraq-Saudi Arabian Neutral Zone
410 Ireland (Eire)
410 Ireland, NOS
404 Ireland, Northern
410 Ireland, Republic of
401 Isle of Man
631 Israel
583 Issas
447 Italy
539 Ivory Coast

**J**

244 Jamaica
423 Jan Mayen
693 Japan
673 Java
401 Jersey
631 Jewish Palestine
127 Johnston Atoll
625 Jordan
453 Jugoslavia

**K**

539 Kameroon
663 Kampuchea
065 Kansas
634 Kazakh S.S.R.
634 Kazakhstan
047 Kentucky
575 Kenya
634 Kirghiz S.S.R.
122 Kiribati
695 Korea
695 Korea, North
695 Korea, South
629 Kuwait
634 Kyrgystan
634 Kyrgyz

**L**

221 Labrador
661 Laos
420 Lapland, NOS
265 Latin America, NOS
459 Latvia
459 Latvian S.S.R. (Latvia)
623 Lebanon
245 Leeward Island, NOS
545 Lesotho
539 Liberia
517 Libya
437 Liechtenstein
122 Line Islands, Southern
461 Lithuania
461 Lithuanian S.S.R. (Lithuania)
073 Louisiana
434 Luxembourg

**M**

686 Macao
686 Macau
453 Macedonia
555 Madagascar
445 Madeira Islands
002 Maine
555 Malagasy Republic
551 Malawi
671 Malay Peninsula
671 Malaysia
640 Maldives
520 Mali
491 Malta
224 Manitoba
129 Mariana Islands
221 Maritime Provinces, Canada
131 Marshall Islands
245 Martinique
021 Maryland
005 Massachusetts
520 Mauritania
580 Mauritius
580 Mayotte
490 Mediterranean Islands, Other
721 Melanesian Islands
610 Mesopotamia, NOS
230 Mexico
041 Michigan
123 Micronesian Islands
640 Mid-East Asia
132 Midway Islands
052 Minnesota
249 Miquelon
039 Mississippi
063 Missouri
456 Moldavia
456 Moldavian S.S.R.
456 Moldova
441 Monaco
691 Mongolia
056 Montana
453 Montenegro
245 Montserrat
452 Moravia
511 Morocco
080 Mountain States
553 Mozambique
629 Muscat
649 Myanmar (see Burma)

**N**

545 Namibia
133 Nampo-shoto, Southern
545 Natal
723 Nauru
610 Near-East Asia
067 Nebraska
643 Nepal
432 Netherlands
245 Netherlands Antilles
332 Netherlands Guiana
085 Nevada
245 Nevis
221 New Brunswick
725 New Caledonia

001 New England
673 New Guinea, except Australian and North East
711 New Guinea, Australian
711 New Guinea, North East
003 New Hampshire
721 New Hebrides
008 New Jersey
086 New Mexico
011 New York
715 New Zealand
221 Newfoundland
255 Nicaragua
520 Niger
531 Nigeria
715 Niue
510 North Africa, NOS
260 North America, NOS (use more specific term if possible)
240 North American Islands
671 North Borneo (Malaysia)
025 North Carolina
040 North Central States
054 North Dakota
711 North East New Guinea
695 North Korea
010 North Mid-Atlantic States
499 Northern Europe, NOS
404 Northern Ireland
129 Northern Mariana Islands
050 Northern Midwest States
549 Northern Rhodesia
711 Norfolk Island
225 Northwest Territories (Canada)
423 Norway
998 Not United States, NOS
221 Nova Scotia
227 Nunavut
551 Nyasaland

**O**

720 Oceania
043 Ohio
075 Oklahoma
629 Oman
223 Ontario
545 Orange Free State
095 Oregon
403 Orkney Islands

**P**

120 Pacific area, U.S. possessions
720 Pacific Islands
123 Pacific Islands, Trust Territory of the (code to specific islands if possible)
090 Pacific Coast States
639 Pakistan
645 Pakistan, East
639 Pakistan, West
139 Palau (Trust Territory of the Pacific Islands)
625 Palestine, Arab
631 Palestine, Jewish
631 Palestine, NOS
631 Palestinian National Authority--PNA
257 Panama
711 Papua New Guinea
371 Paraguay
014 Pennsylvania
629 People's Democratic Republic of Yemen
682 People's Republic of China
637 Persia
629 Persian Gulf States, NOS
351 Peru
675 Philippine Islands
675 Philippines
122 Phoenix Islands
725 Pitcairn Islands
451 Poland
725 Polynesian Islands
445 Portugal
539 Portuguese Guinea
224 Prairie Provinces, Canada
221 Prince Edward Island
543 Principe
101 Puerto Rico

**Q**

629 Qatar
222 Quebec

**R**

684 Republic of China
545 Republic of South Africa
580 Reunion
006 Rhode Island
547 Rhodesia
549 Rhodesia, Northern
547 Rhodesia, Southern

539 Rio Muni
440 Romance-language Countries
449 Romania
449 Roumania
577 Ruanda
449 Rumania
455 Russia, NOS
457 Russia, White
455 Russian Federation (former U.S.S.R.)
455 Russian S.F.S.R.
577 Rwanda
134 Ryukyu Islands (Japan)

**S**

520 Sahara, Western (Spanish)
121 Samoa, American
725 Samoa, Western
245 St. Christopher-Nevis
580 St. Helena
245 St. Kitts
245 St. Lucia
249 St. Pierre
245 St. Vincent
447 San Marino
543 Sao Tome
447 Sardinia
224 Saskatchewan
629 Saudi Arabia
420 Scandinavia
403 Scotland
539 Senegal
453 Serbia
580 Seychelles
403 Shetland Islands
651 Siam
447 Sicily
539 Sierra Leone
643 Sikkim
671 Singapore
450 Slavic Countries
453 Slavonia
452 Slovak Republic
452 Slovakia
453 Slovenia
721 Solomon Islands
581 Somali Republic
581 Somalia
581 Somaliland
583 Somaliland, French
540 South Africa
545 South Africa, Republic of
545 South Africa, Union of
300 South America
380 South American Islands
026 South Carolina
055 South Dakota
695 South Korea
020 South Mid-Atlantic States
545 South West Africa
650 Southeast Asia
030 Southeastern States
499 Southern Europe, NOS
122 Southern Line Islands
070 Southern Midwest States
133 Southern Nampo-shoto
547 Southern Rhodesia
629 Southern Yemen
—— Soviet Union (see individual republics)
443 Spain
520 Spanish Sahara
647 Sri Lanka (see Ceylon)
520 Sudan (Anglo-Egyptian Sudan)
520 Sudanese Countries
673 Sumatra
332 Suriname
423 Svalbard
135 Swan Islands
545 Swaziland
427 Sweden
435 Switzerland
621 Syria

**T**

634 Tadzhik S.S.R.
684 Taiwan
634 Tajikistan
571 Tanzania
571 Tanganyika
571 Tanzanyika
031 Tennessee
077 Texas
651 Thailand (Siam)
685 Tibet
245 Tobago
539 Togo
136 Tokelau Islands
725 Tonga
665 Tonkin
625 Trans-Jordan
545 Transkei
545 Transvaal
449 Transylvania
245 Trinidad

517 Tripoli
517 Tripolitania
629 Trucial States
515 Tunisia
611 Turkey
634 Turkmen S.S.R.
634 Turkmenistan
245 Turks Islands
125 Tuvalu

**U**

573 Uganda
456 Ukraine
456 Ukranian S.S.R.
404 Ulster
545 Union of South Africa
—— Union of Soviet Socialist Republics (U.S.S.R.) (see individual republics)
629 United Arab Emirates
519 United Arab Republic
400 United Kingdom
000 United States
102 U.S. Virgin Islands
999 Unknown
520 Upper Volta
375 Uruguay
579 Urundi
084 Utah
634 Uzbekistan
634 Uzbek S.S.R.

**V**

721 Vanuatu
447 Vatican City
545 Venda
321 Venezuela
004 Vermont
665 Vietnam
245 Virgin Islands (British)
102 Virgin Islands (U.S.)
023 Virginia

**W**

137 Wake Island
402 Wales
449 Wallachia
721 Wallis
093 Washington (state)
022 Washington D.C.
530 West Africa, NOS
539 West African Countries, other
631 West Bank
431 West Germany
245 West Indies, NOS (see also individual islands)
639 West Pakistan
024 West Virginia
499 Western Europe, NOS
520 Western (Spanish) Sahara
725 Western Samoa
457 White Russia
245 Windward islands
051 Wisconsin
082 Wyoming

**Y**

629 Yemen
629 Yemen, People's Democratic Republic of
453 Yugoslavia (former Yugoslavia region)
225 Yukon Territory

**Z**

541 Zaire
549 Zambia
571 Zanzibar
547 Zimbabwe

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2. Registry Organization

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**Registry Staffing Manual.** American College of Surgeons, 55 East Erie, Chicago, Illinois 60611.

Watkins, Sue. **Tumor Registry Management**, 1988. 187pp., The Tumor Registrars Association of California. $15.00. Cancer Program Coordinator, Loma Linda Medical Center, 11234 Anderson St., Loma Linda, CA. 92354. A comprehensive manual which covers the organization of tumor registry.

**Standards of the Commission on Cancer, Vol II: Registry Operations and Data Standards.** American College of Surgeons, 55 East Erie, Chicago, Illinois 60011-2797. Contains the guidelines for coding, an explanation of the different data sets, and the coding schemes and rules for each data item.

**Standards for Cancer Registries, Volumes I, II, III, and IV.** North American Association of Central Cancer Registries, 601 North 7th St., P.O. Box 942732, Sacramento, CA. 94234-7320.

3. General References

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4. Self Instructional Manuals

**Self Instructional Manuals for Tumor Registrars,** SEER Program, National Cancer Institute Demographic Analysis Section, Blair Building, room 532, 9000 Rockville Pike, Bethesda, MD. 20205. Free of charge. Book 1-7.

5. Journals

**CA-Cancer Journal for Clinicians.** Published six times a year by the American Cancer Society. Check with you local office of the American Cancer Society. Free.

**Cancer News.** Published three times a year by the American Cancer Society. Free.

**COPE,** Pulse Publications, Inc. 12600 West Colfax Ave., Suite B400, Denver, Co., A bimonthly journal for cancer patients and their families.

**The Journal of Cancer Program Management.** Association of Community Cancer Centers, 11600 Nebel St., Suite 210, Rockville, MD. 20852. $40.00 per year individual, $60.00 per year organization. ACCC membership covers general and delegate member subscriptions.

**Oncology Times - The Newspaper for Specialists in Cancer.** Herlitz Publications, 404 Park Ave., South, New York, NY, 10016. $26.00 per year, published monthly.

6. Medical Dictionaries

**Blakeston's Gould Medical Dictionary,** 4th. Ed., McGraw-Hill, 1979.

**Butterworth's Medical Dictionary.** 2nd. Ed., Butterworth's Publishers, 1978.

**Dorland's Illustrated Medical Dictionary,** W.B. Saunders Comp.

**Melloni's Illustrated Medical Dictionary,** Williams and Wilkins, Publishers.

**Stedman's Medical Dictionary,** Williams and Wilikins Publishers.

7. Statistical Methods and Epidemiology

Phillips, David S. **Basic Statistics for Health Science Students,** W.H. Freeman, 209 pp. 1978. This is an introductory book that covers a wide variety of statistical problems, and is designed for those who have had a course in statistics. It is directed towards statistics as applied specifically to the health sciences.

**Reporting of Cancer Survival and End Results,** American Joint Committee on Cancer, 55 East Erie St., Chicago, Illinois 60611, 1982, 12 pp., free of charge.
Describes the materials used for calculating survival rates followed by specific methods for calculating survival rates, direct and actuarial methods, adjusted and relative survival rates, as well as the method of calculating the standard error of the aforementioned survival rates.

Austin, Donald F. And Werner, S. Benson. **Epidemiology for the Health Services: A Primer on Epidemiologic concepts and Their Uses,** Charles C. Thomas, 88pp. 1982. This book discusses the basic concepts of epidemiology.

Lilenfeld, Abraham, M. & Lilienfeld, David E. **Foundations of Epidemiology,** Oxford University Press, 2nd ed., 1980. This book presents the concepts and methods of epidemiology as they are applied to a variety of disease problems.

Ries LAG, Hankey BF, Miller BA, et. al. **Cancer Statistics Review 1973-1988.** National Cancer Institute. NIH Pub. NO. 91-2789, 1991. This is the annual report of the national SEER program.

Glantz, Stanton A. **Primer of Biostatistics.** McGraw-Hill. 1981. Introductory guide to use of statistics in the medical literature.

Abramson, J. H. **Making Sense of Data.** Oxford University Press. 1988. It is, as the sub-title says, Aa self-instruction manual on the interpretation of epidemiological data."

Schottenfeld, D. and Fraumeni, J. F., eds. **Cancer Epidemiology and Prevention.** W. B. Saunders. 1982. Chapters organized by major risk factors, tissue of origin, control measures and general topics.

**Cancer Incidence and Mortality,** Michigan Dept. Of Public Health. Office of the State Registrar. Annual report of the incidence of cancer in Michigan. 1985- Yearly report.

8. Miscellaneous

**Cancer Information Service 1-800-4cancer.** This telephone number is a cancer resource Ahot-line" which will provide information concerning all aspects of cancer diagnosis and treatment. Many publications are available through the mail.

9. Coding

**International Classification of Diseases for Oncology, ICD-0 2 second edition.** WHO Publications Center, 49 Sheridan Avenue, Albany, NY. 12210. Newly revised in 1990. A must for all approved hospital registry programs. Accepted worldwide coding structure for site and morphology of tumors.

10. Staging

**Manual for Staging of Cancer.** Fourth edition. American Joint Committee on Cancer. J. B. Lippincott Co., East Washington Square, P.O. Box 1430, Philadelphia, Pa 19105.

**T-N-M Atlas.** Illustrated Guide to the TNM/pTNM-Classification of Malignant Tumors. Second editions. International Union Against Cancer. Springer Verlag, New York, Inc. Attn: M. Connor, 175 fifth Ave., New York, N. Y.

**Collaborative Stage Data Collection System Manual**, Collaborative Staging Task Force of the American Joint Committee on Cancer. Collaborative Stage Data Collection System Manual (CSv02.03). Jointly published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2004, NIH Publication Number 04-5496. Incorporates updates through September 8, 2006.

NOTE: This may not be a complete listing of the references used to develop this manual. We apologize in advance if we did not appropriately reference a source.